Massachusetts Health Care Cost Trends
Final Report

Appendices C.4a – C.4h:
Presentations
(Presented March 16, 18, and 19, 2010)

April 2010

Deval L. Patrick, Governor
Commonwealth of Massachusetts

Timothy P. Murray
Lieutenant Governor

JudyAnn Bigby, Secretary
Executive Office of Health and Human Services

David Morales, Commissioner
Division of Health Care Finance and Policy

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Note

Page Numbering: The page numbering listed above reflects the compilation for this Appendix-only and not the page numbers that appear in the original documents.

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Massachusetts Health Care Cost Trends Final Report

Appendix C.4a

Health Care Cost Trends Public Hearings Presentations

Review of Analytic Findings from the Division of Health Care Finance and Policy: Introduction and Context

Cindy Parks Thomas, Ph.D., Brandeis University

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The Massachusetts Health Care System in Context

March 2010

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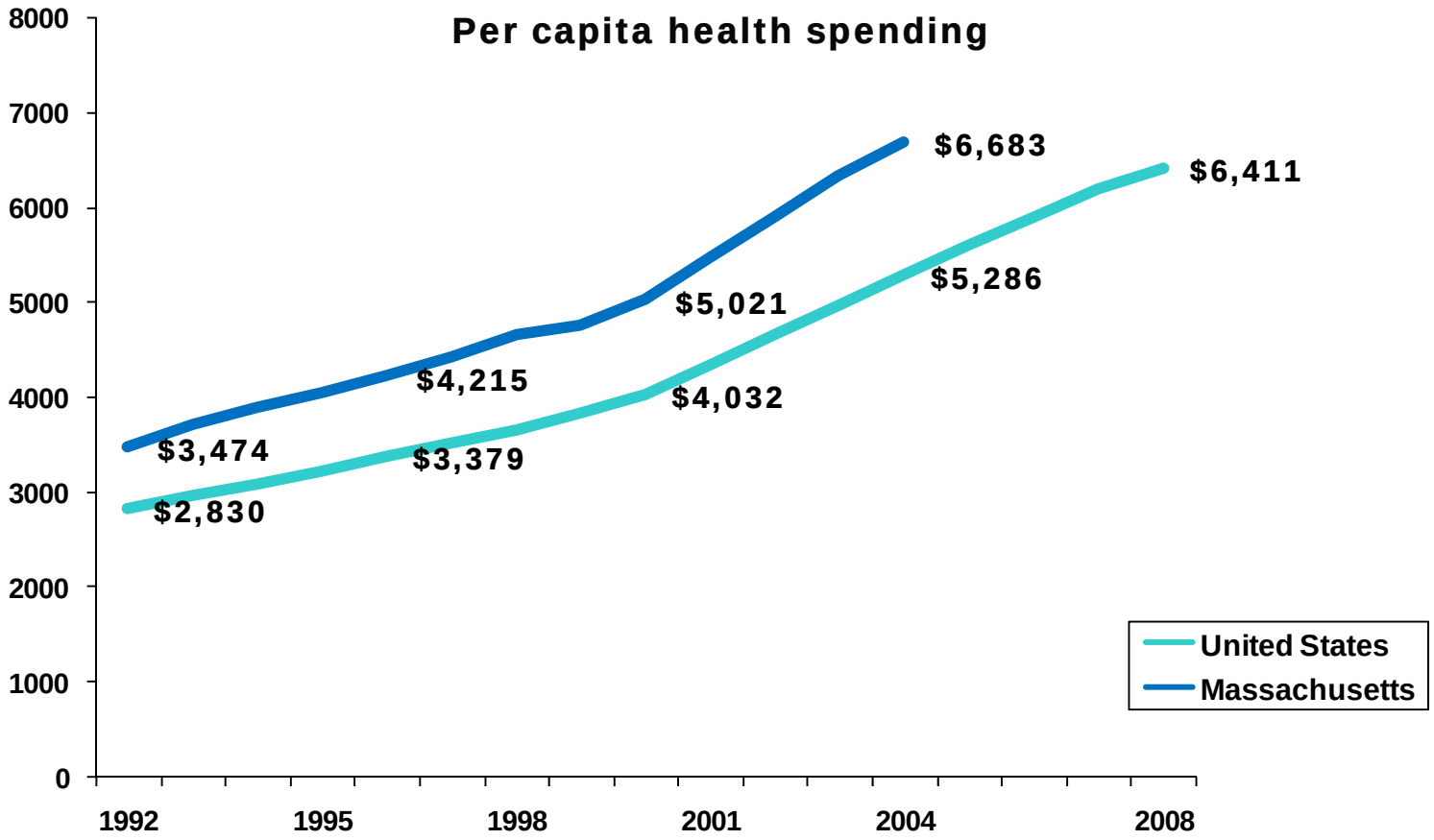
Division of Health Care Finance and Policy

Overview

- Massachusetts Health Spending Trends Compared to the Nation
  - 15% higher than the nation, generous insurance coverage
- The Structure of the Massachusetts Health Care System: Resources, Academic Health Centers, and the Insurance Market
  - Specialization, Academic medicine, and open networks
- Methods Used by Health Insurers to Pay Providers
  - Fee-for-service predominates, even in HMOs
- Conclusion
  - Opportunities for increased efficiency

Massachusetts Health Spending Trends Compared to the Nation

Massachusetts Historically Has Had Higher Health Spending Than the U.S.



- Massachusetts unadjusted health care costs have increased to 27% higher than the U.S.
- Higher costs are driven by many factors: broad insurance coverage and generous benefits; health system structure differences

Source: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group.

Per Capita Personal Health Spending in Massachusetts is Higher than the U.S. for Most Services

Unadjusted and Adjusted for Differences in Non-Patient Revenue and Geographic Wage Index, 2004

	Unadjusted			Adjusted for Non-Patient Revenue & Wage Index*		
	MA	US	Difference	MA	US	Difference
Total	$6,683	$5,283	26.5%	$6,025	$5,243	14.9%
Hospital	$2,620	$1,931	35.7%	$2,242	$1,892	18.5%
Physician	$1,416	$1,341	5.6%	$1,264	$1,341	-5.7%
Other Professional	$200	$1790	11.7%	$179	$179	-0.3%
Dental	$354	$277	27.8%	$316	$277	14.1%
Home Health	$271	$145	86.9%	$250	$145	72.4%
Drugs	$849	$757	12.2%	$849	$757	12.2%
Durable Medical Equipment (DME)	$78	$79	-1.3%	$78	$79	-1.3%
Nursing Home	$641	$392	63.5%	$594	$392	51.6%
Other	$254	$181	40.3%	$254	$181	30.3%

- Even after adjusting for non-patient revenues and wages, Massachusetts per capita
- health spending is 15% higher than the national average
- Differences are due to both price and utilization of services

Source: National Health Expenditure Accounts, Centers for Medicare and Medicaid Services
*Based on Medicare geographic wage index and Geographic \Adjustment Factor (GAF) applied to labor portion of spending by category.

Outpatient Hospital Use in Massachusetts is Higher Than the U.S. Average, 2007

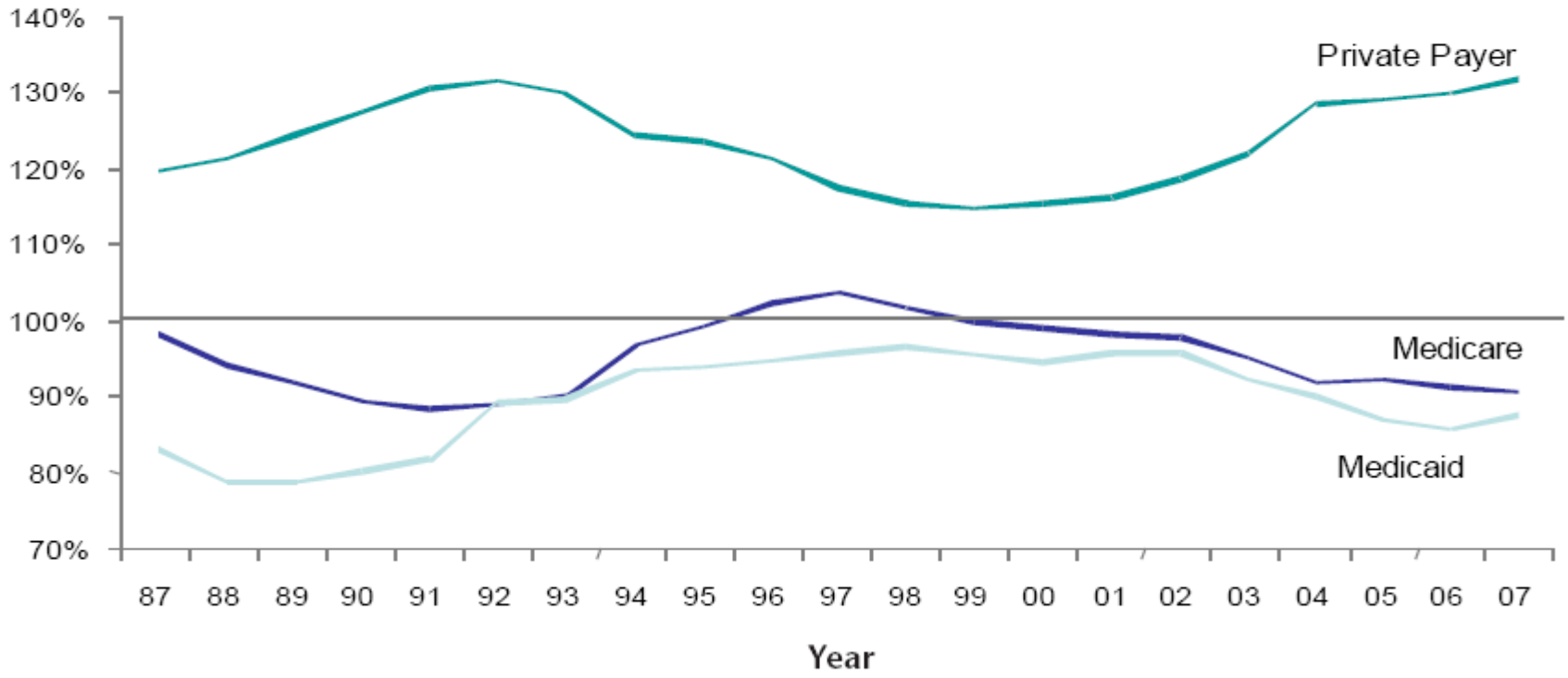
	Utilization per 1,000 population		
	Massachusetts	U.S.	MA/U.S. difference
Inpatient			
Beds	2.5	2.7	-7.40%
Inpatient days	688.5	657.3	4.70%
Admissions	129.7	118.4	9.50%
Average length of stay	5.3	5.6	-5.4
Outpatient			
Emergency dept visits	487.7	396.2	23.10%
Other hospital outpatient visits	2,548.40	1,610.60	58.20%

- Massachusetts use of hospital inpatient care is slightly higher than the national average
- Outpatient hospital utilization is 58% higher, suggesting that this is not replacing inpatient care
- For Medicare services, Massachusetts is no higher in utilization than the national average
- Massachusetts is among the highest in the nation in availability of commonly used high tech outpatient services

Source: American Hospital Association Annual Survey

U.S. Hospitals Shift Costs to Private Payers, 1987-2007

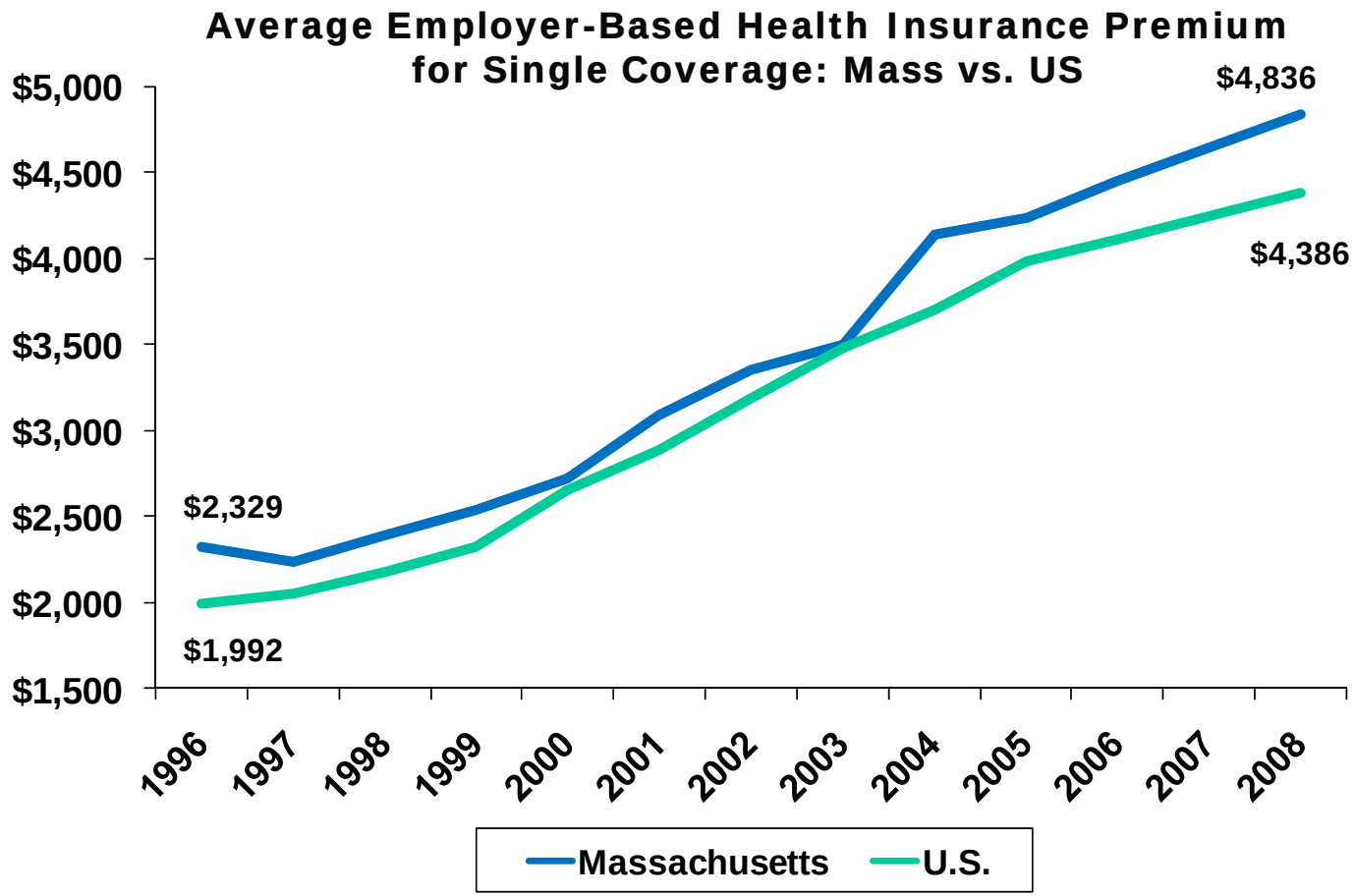
Percent of hospital costs that are paid by each payer



- Higher prices are paid by private insurers nationally, as Medicare and Medicaid prices have limited price increases
- In 2007, private payers nationally on average paid 132% of costs, and Medicaid paid 90% of costs

Note: Medicaid payments include Medicaid Disproportionate Share payments.
Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2007

Average Employer-based Health Insurance Premiums Higher in Massachusetts than U.S. Average, and Difference Is Increasing

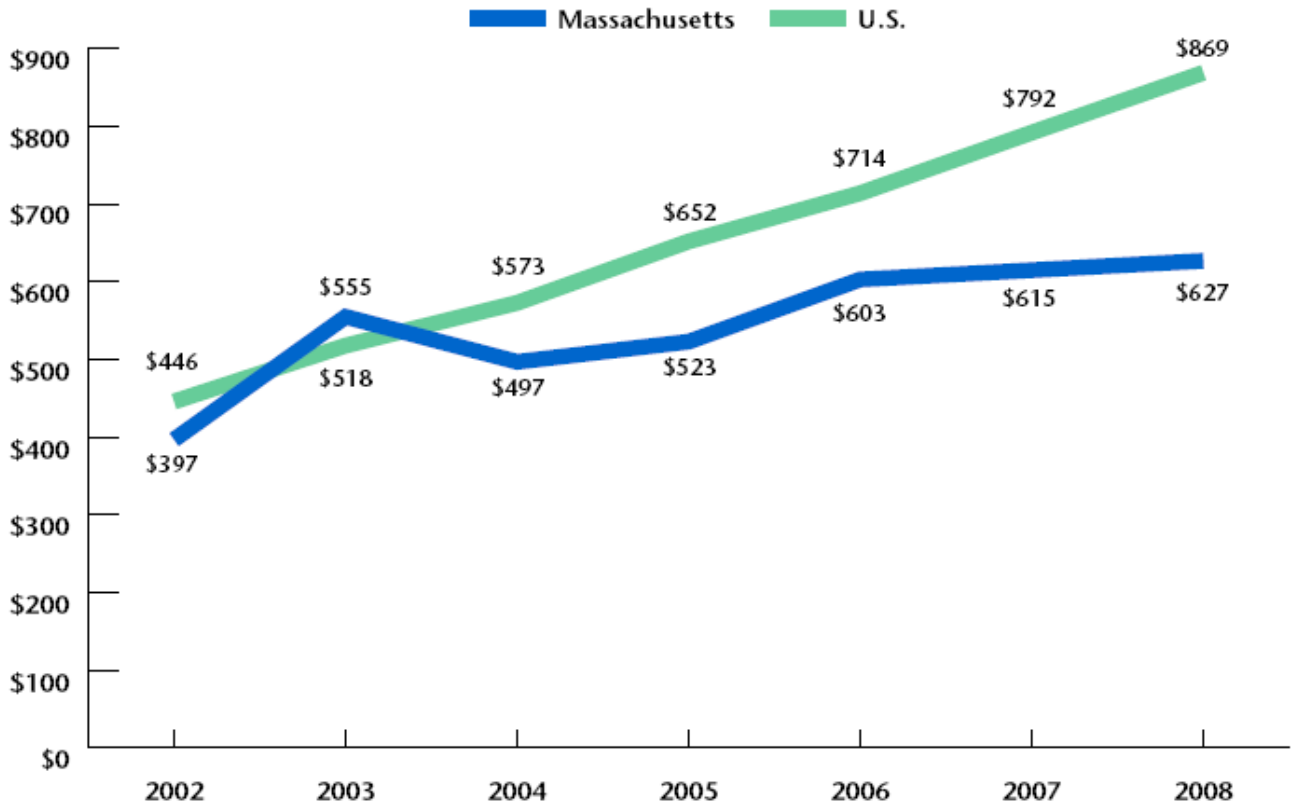


• Massachusetts health care premiums are higher than the nation, due to more generous benefits and higher health costs

Source: Agency for Health Care Quality and Research Medical Expenditure Panel Survey.

Massachusetts Insurance Coverage Is More Generous than the U.S. Average

Average Individual Deductible in Employer-Sponsored Plans in Massachusetts and the U.S., 2002-2008



- The average individual deductible in Massachusetts is 38% lower than the U.S. average
- As part of health reform, Massachusetts has minimum coverage requirements

Source: Agency for Health Care Quality and Research Medical Expenditure Panel Survey.

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The Structure of the Massachusetts Health Care System: Resources, Academic Health Centers, and the Insurance Market

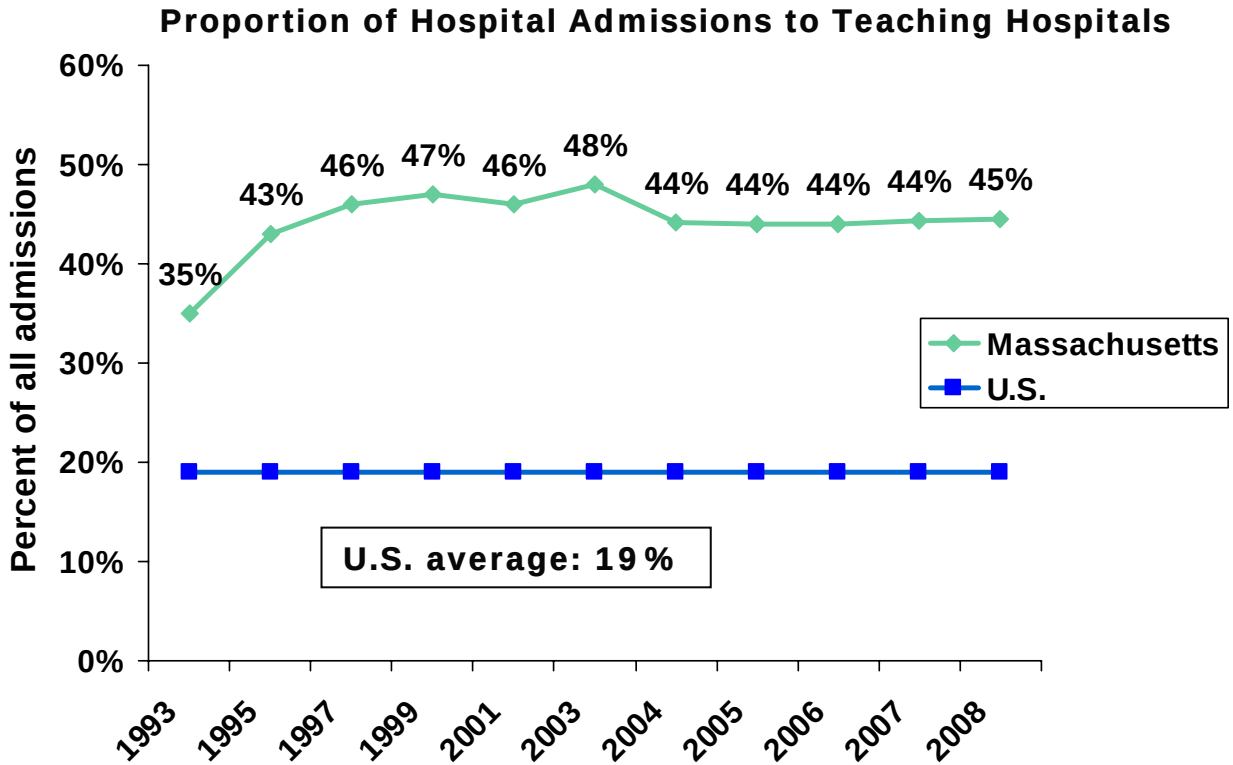
Massachusetts Has More Health Personnel per Capita than the U.S. Average

	Personnel per 1,000 population		
Workforce personnel	**Massachusetts**	**U.S.**	**MA/U.S. ratio**
Non-federal Physicians	5.28	3.30	1.60
Non-federal PCPs	1.78	1.30	1.40
Non-federal Specialists	3.50	2.00	1.80
Active Physicians	4.28	2.70	1.60
Physicians in Patient Care	3.90	2.53	1.50
Employed RNs	1.18	0.83	1.40
RNs total	1.23	0.84	1.50
Physicians Assistants	0.27	0.24	1.10
Dentists	1.10	0.80	1.40

- Massachusetts has 80% more specialist physicians than the U.S. average
- Massachusetts has more behavioral health providers, ranking first in number of psychiatrists per capita and third in psychologists

Source: Kaiser Family Foundation, Health U.S., Health Resources and Service Administration

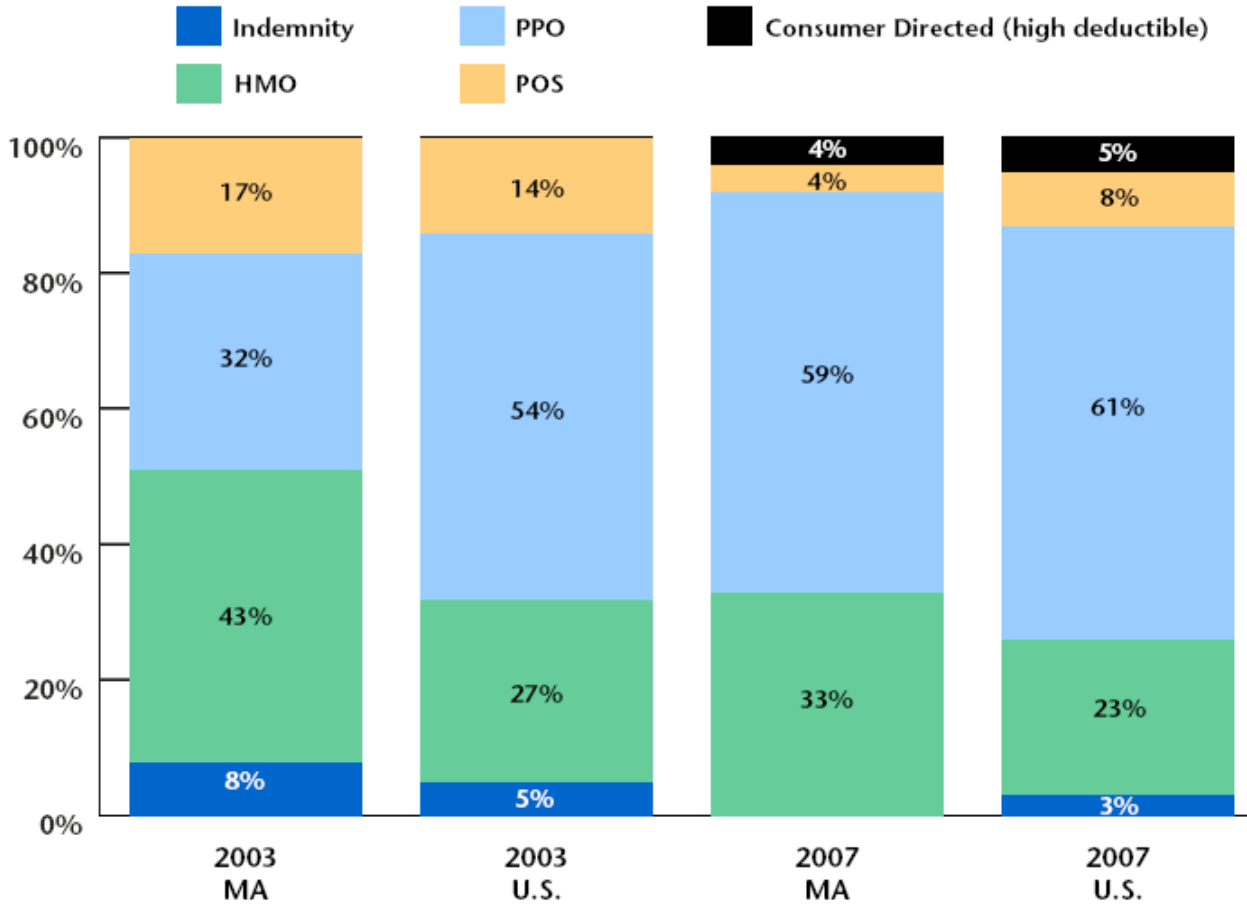
Teaching Hospital Admissions in Massachusetts Make Up a Larger Proportion of Hospital Admissions Compared to the U.S



- Teaching hospitals on average have higher costs per service
- In the 1990s many non-teaching hospitals closed, leading to consolidation of services
- In 2007, the per capita economic activity generated by academic medicine in Massachusetts was by far the highest among the 28 states studied, and was about 2.8 times a 28-state average

Source: Massachusetts Council of Community Hospitals; Massachusetts Division of Health Care Finance and Policy.
Teaching hospitals have more than 25 full-time medical residents per 100 inpatient beds.

Insurance Market: Enrollment in Employer-Sponsored Preferred Provider Organization (PPO) Health Plans Is Growing in Both Massachusetts and the U.S



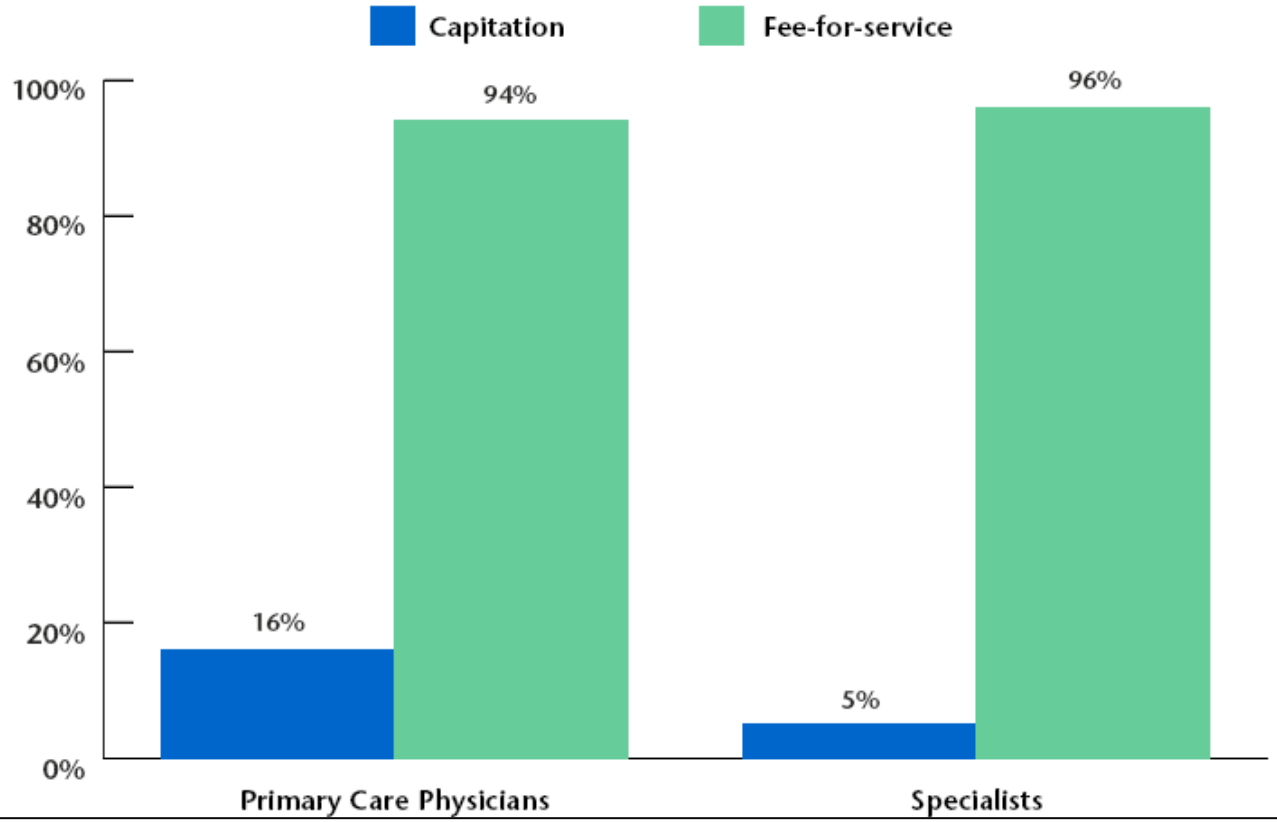
- Type of insurance does not determine how physicians are paid, as HMOs in Massachusetts can use the same payment methods as PPOs
- Most health plans in Massachusetts have large networks
- Half of privately insured covered lives are through self-insured employers

Source: Mercer National Survey of Employer-sponsored Health Plans

Methods Used by Health Insurers to Pay Providers in Massachusetts

Fee-for-Service Payments Are the Predominant Mode of Physician Payment by Massachusetts Commercial HMO Products

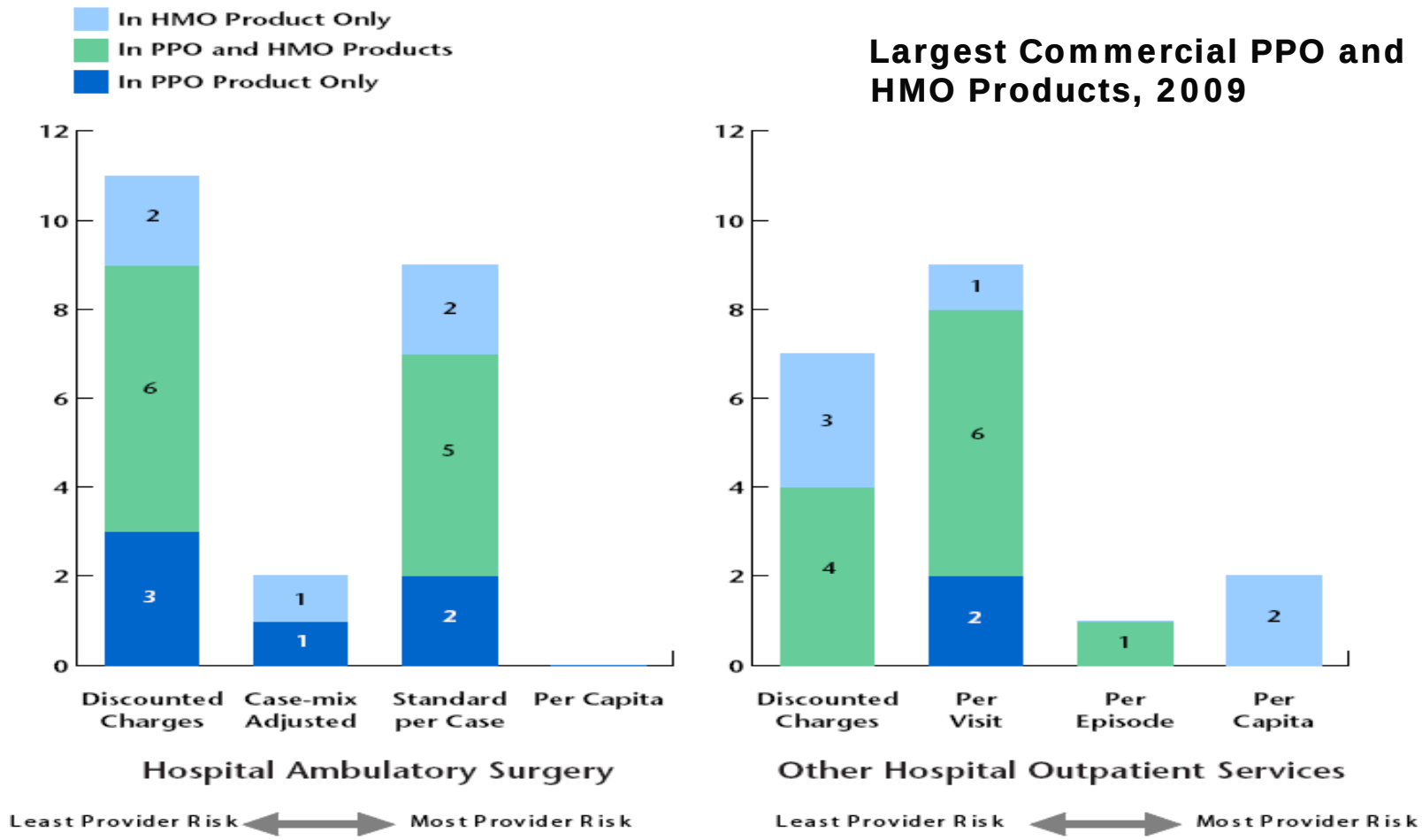
Proportion of physicians paid by various methods by plans that use any capitation



- No PPOs use capitation payments
- Six out of 10 large HMOs use capitation for some providers, but for a small proportion
- Public payers (Medicare and Medicaid) have higher rates of paying physicians by capitation
- Some payers are building from fee-for-service, using bundled services, medical home payments, and pay for performance

Source: Mathematica Policy Research analysis of Division of Health Care Finance and Policy Survey of Health Plans, 2009

Hospitals Share Little Risk with Health Insurers in Payment Methods for Outpatient Hospital Services



- For inpatient services, most payers use diagnostic related group (DRG) payments, per diem, with some discounted charges.
- For outpatient services, most insurers use a mix of discounted charges and per case (for ambulatory surgery) or per visit

Source: Mathematica Policy Research analysis of Division of Health Care Finance and Policy Survey of Health Plans, 2009

Conclusions

Key System Cost Drivers

- Dominance of fee-for-service
- Open networks with limited pressure to decrease price
- Generous insurance coverage, and low cost sharing
- Greater use of outpatient hospital care, but not necessarily as a substitute for inpatient
- High use of academic medical centers which have higher prices

Opportunities for Increased Efficiency While Maintaining our High Quality Health System

- The dominance of fee-for-service suggests payment reform is necessary
- Use of more limited networks warrants consideration
- Massachusetts' generally low cost sharing provides opportunity to redesign benefits, but necessitates education consumers on using low-cost, high quality providers
- Outpatient hospital care and other services can be moved to less costly settings

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Massachusetts Health Care Cost Trends Final Report

Appendix C.4b

Health Care Cost Trends Public Hearings Presentations

Review of Analytic Findings from the Division of Health Care Finance and Policy: Private Health Insurance Premium Trends

Dianna Welch, P.S.A., M.A.A.A.,
Oliver Wyman Actuarial Consulting Group

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Premium Trends

March 2010

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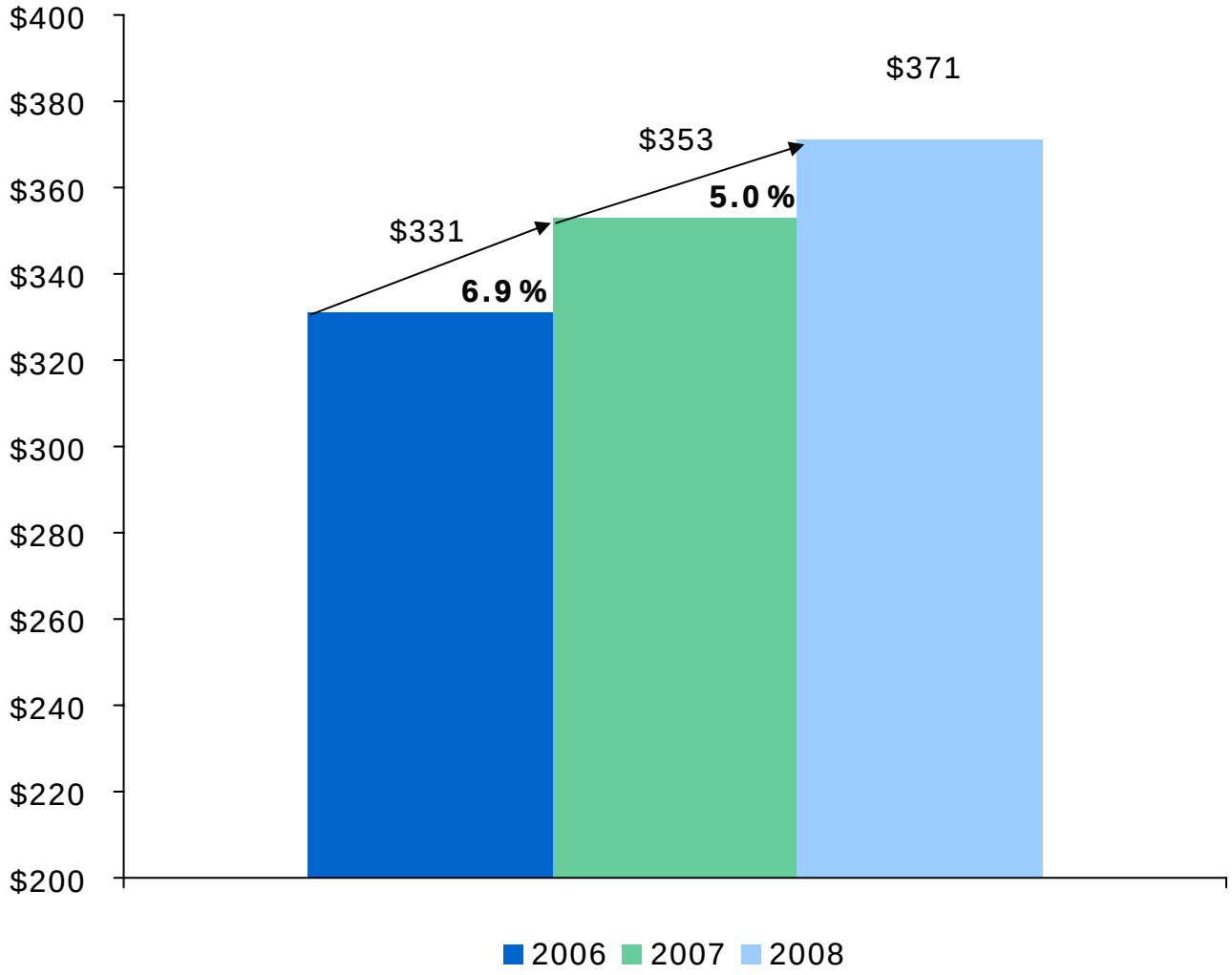
Average Private Insurance Premiums PMPM: All Market Segments Combined



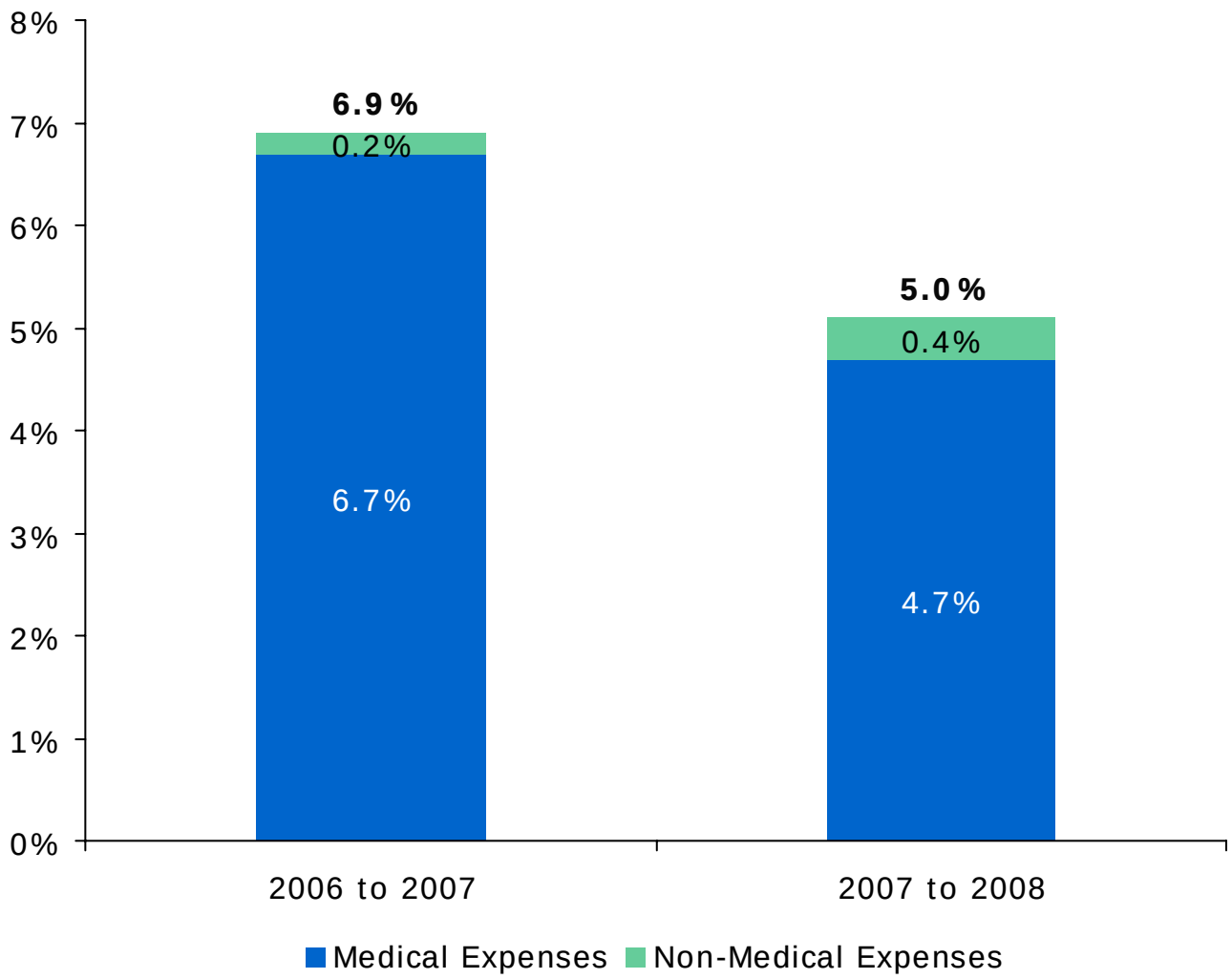
Premiums grew more slowly in 2008 (5.0%) than they did in 2007 (6.9%) across all market segments, on average.

These premium increases reflect changes in benefits, which result in lower increases than what would have been experienced if benefits were constant.

Note: For any specific employer group, premium levels and trends can vary substantially from the average.

Note: These figures refer to all Massachusetts fully-insured groups across all group sizes. Trends shown are based on unadjusted un-rounded premiums.

Components of Premium Growth

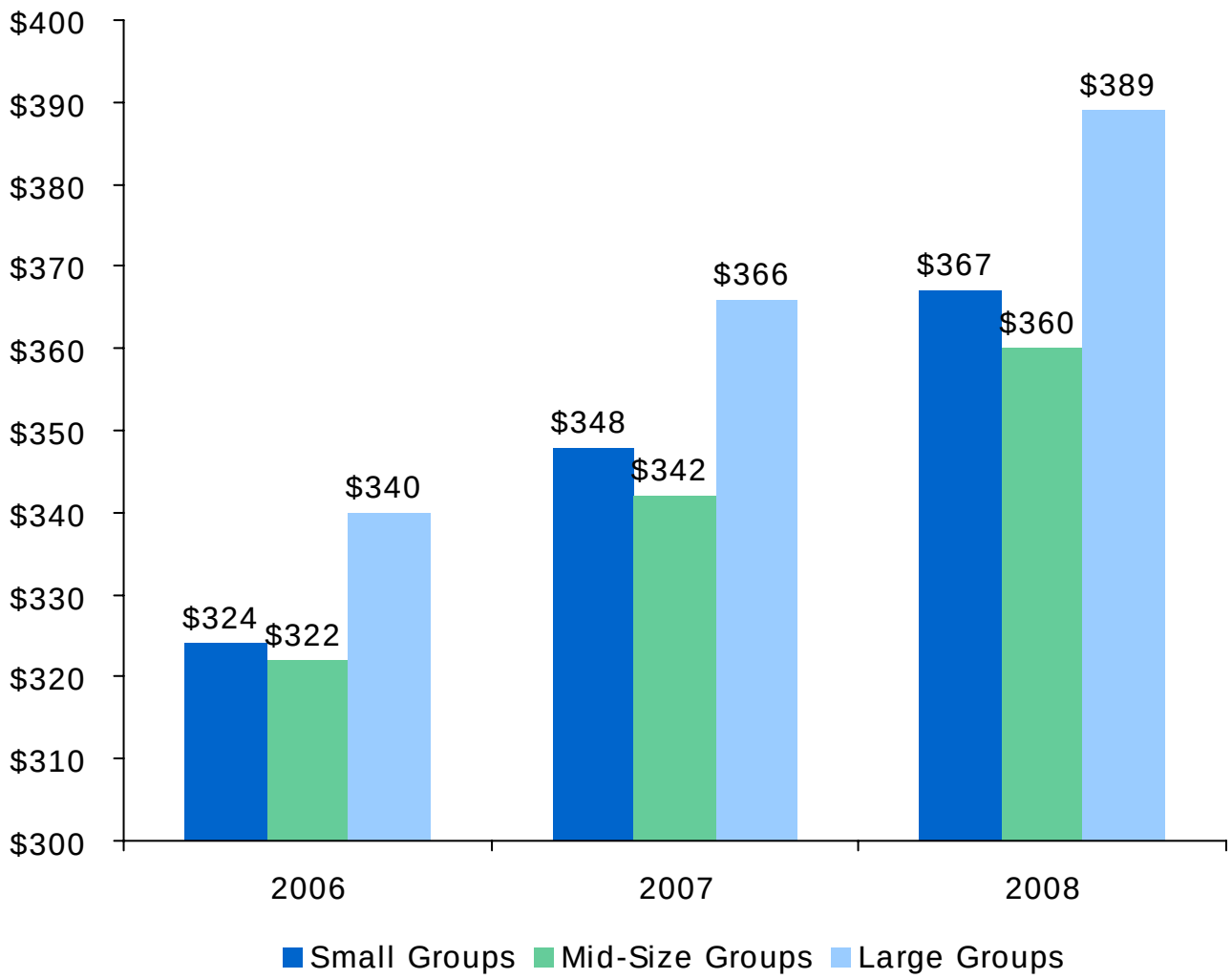


Ninety-seven percent (97%) of the total premium growth from 2006 to 2007 and 94% of the total premium growth from 2007 to 2008 was attributable to medical expenses.

This is because medical expenses represent roughly 88% of the total premium, and medical expenses have grown at a faster rate than non-medical expenses over this time period.

Note: These figures refer to all Massachusetts fully-insured groups across all group sizes. 2007 to 2008 components do not sum to the total due to rounding.

Average Monthly Private Insurance Premiums PMPM by Market Segment



Large groups pay higher premiums than small and mid-size groups.

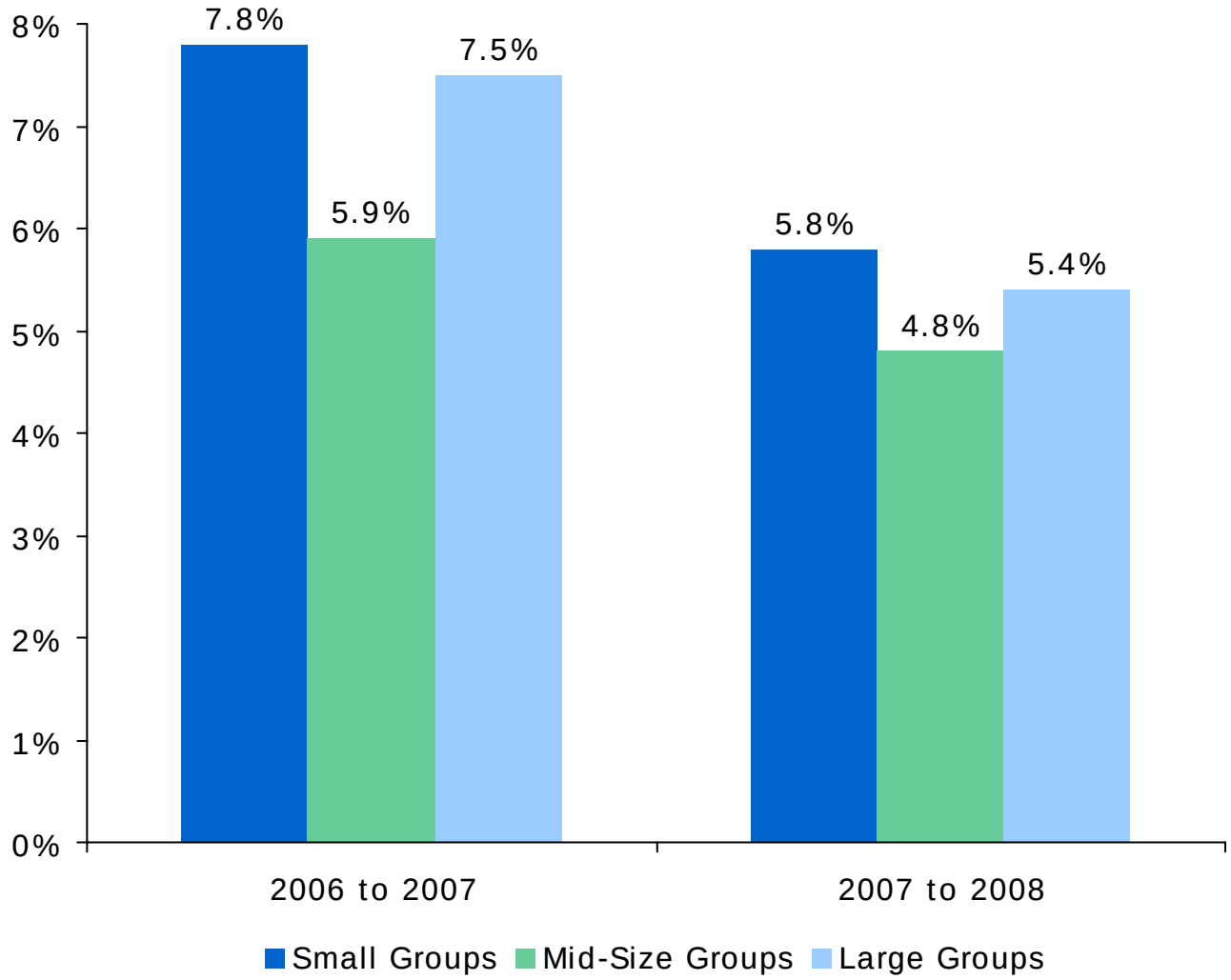
This is due to the richer benefits that they purchase, on average. In addition, geographic and demographic differences among the sectors lead to higher large group premiums.

Note: For any specific employer group, premium levels and trends can vary substantially from the average.

Note: Trends shown are based on unadjusted premiums.

Annual Growth in Premiums PMPM Adjusted for Benefits and Demographics by Market Segment

(Annual Percent Increase)



After adjusting for differences in benefits, geographic location, and demographics among the three market segments, small employers have higher premium trends than mid-size and large groups. In addition, the small groups pay higher premiums than mid-size and large groups.

Higher premium trends among small groups appears to be driven by medical spending, rather than non-medical spending.

Note: For any specific employer group, premium levels and trends can vary substantially from the average.

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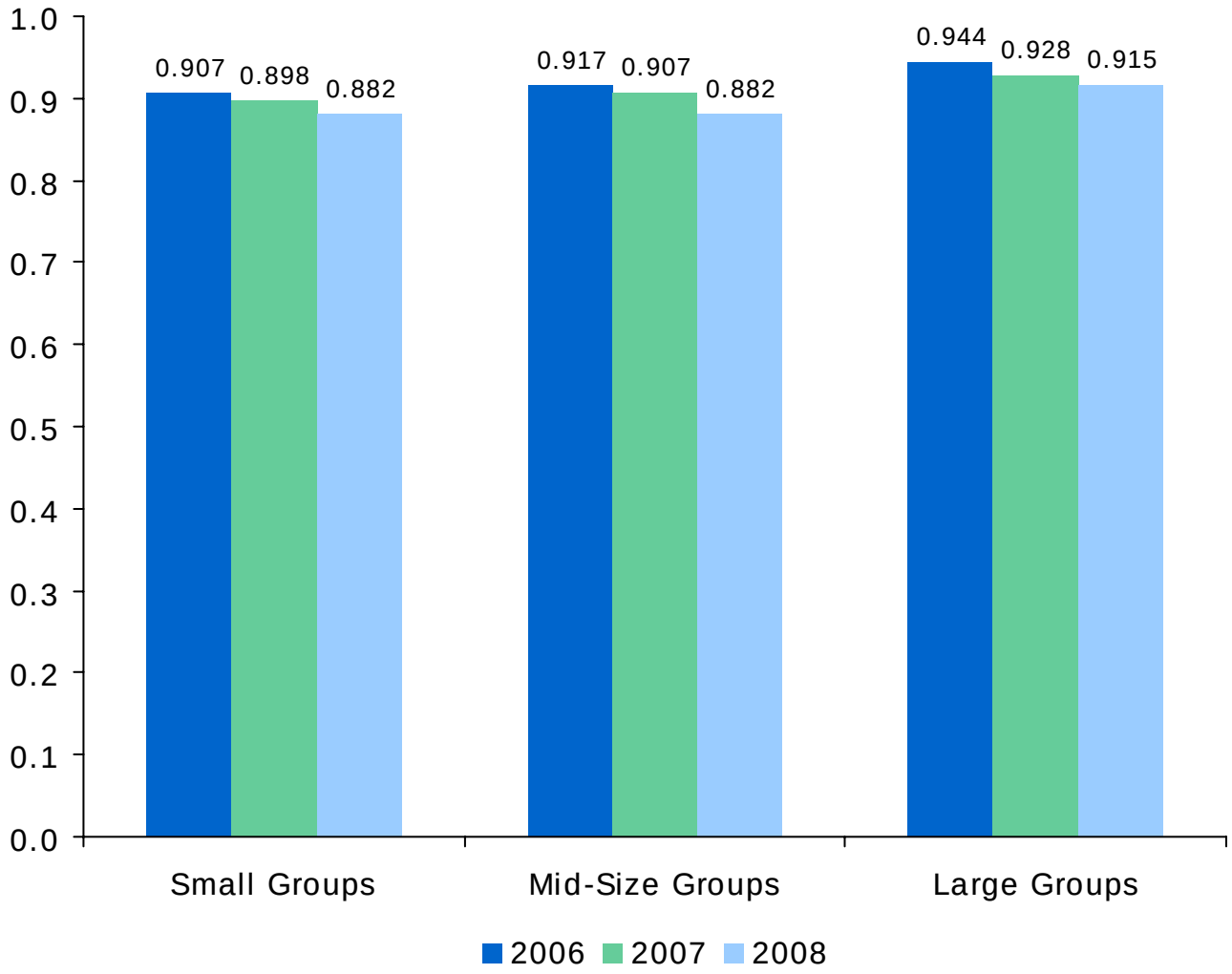
Benefit Levels
by Market Segment

Benefit Reductions Across All Market Segments' Most Popular Products

Median Actuarial Value by Market Segment



All group segments have experienced decreases in benefits for the median **most popular product**.

However, on average **across all products**, mid-size and large groups have had very little change in benefits over this period. Small groups have reduced benefits more significantly.

Health Plan Spending on Non-Medical Expenses by Market Segment

Non-Medical Spending as Percent of Premium in Massachusetts

by Market Segment

Average Non-Medical Expenses as a Percent of Premium by Market Segment, Second Quarter 2009

	Small Group (1-50)	Mid-Size Group (<500)	Large Group (500+)
Administration	7.5%	6.1%	6.2%
Commissions	2.1%	2.4%	1.2%
Contribution to Surplus	2.8%	2.8%	2.2%
Total Non-Claims Expenses	**12.4%**	**11.3%**	**9.6%**
Total Claims Expenses (100% minus Non-Claims Expenses)	**87.6%**	**88.7%**	**90.4%**

Small groups contribute a higher percent of premium to fund non-medical expenses than mid-size groups, and large groups contribute the lowest percent of premium.

The difference in non-medical expenses may be due in part to higher administrative expenses in the small group market where fixed administrative costs must be spread over a smaller population base.

Note: This chart excludes data from a large Massachusetts HMO.

Growth in Non-Medical Spending Per Member Per Month

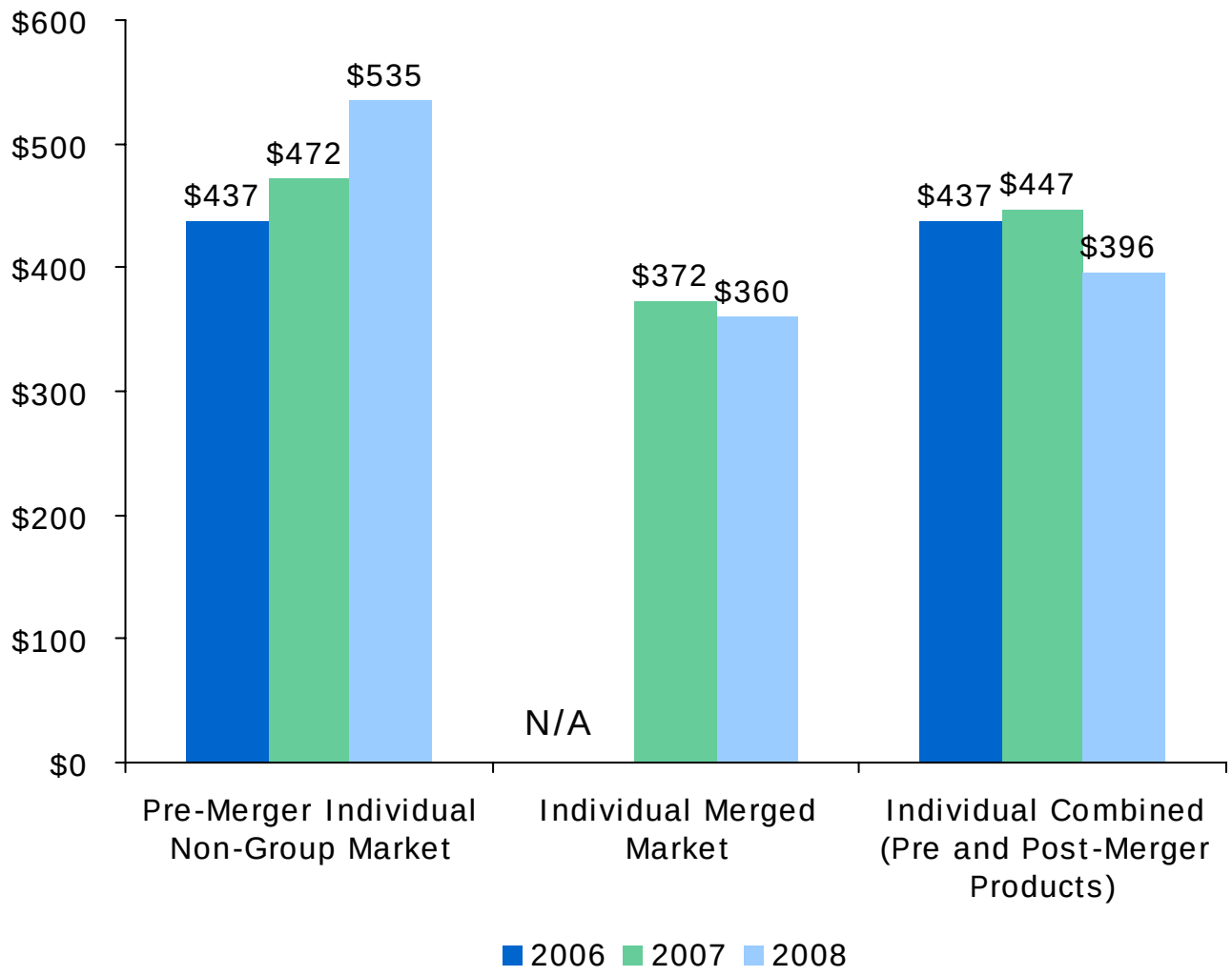
Estimated Average Annual Growth in Non-Medical Spending PMPM by Insurance Market Segment, 2006-2008			
	2006 - 2007	2007 - 2008	Average Annual Growth Rates
Small Groups	5.1%	-4.2%	0.3%
Mid-Size Groups	-0.6%	2.4%	0.9%
Large Groups	-1.2%	10.1%	4.3%

The differential in non-medical expense charges between the market segments has narrowed over the last two years, both as a percent of premium and PMPM.

Note: These figures refer to all Massachusetts fully-insured groups.

Preliminary Experience of the Merged Market

Average Private Insurance Premiums PMPM for the Individual Market



On average, premiums in the individual merged market in 2008 were 33% lower than premiums in the non-group market. This is likely due to a combination of the new rating rules and risk pooling for individuals in the merged market, as well as the reduction in benefits purchased by individuals through the merged market compared with the non-group market.

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Medical Expense Ratios by Market Segment

	2005 Medical Expense Ratio	2006 Medical Expense Ratio	2007 Medical Expense Ratio	2008 Medical Expense Ratio
Individual Pre-Merger	90.2%	95.3%	96.3%	95.4%
Individual Post-Merger Products	N/A	N/A	105.4%	112.0%
Individual Total	90.2%	95.3%	98.2%	107.5%
Small Group	84.3%	86.7%	86.6%	86.1%
Merged Market Total	**N/A**	**N/A**	**86.9%**	**88.1%**
Mid-Size Group	**85.1%**	**86.9%**	**87.7%**	**88.0%**
Large Group	**88.0%**	**89.1%**	**90.0%**	**89.6%**
Total	85.9%	87.7%	88.3%	88.6%

Medical expense ratios for most market segments increased from 2005 to 2008.

The proportion of premium dollars devoted to medical expenses is much higher, on average, for the individual market than for other markets, in part due to the rating restrictions in the merged market.

The inclusion of individuals in the merged market increases the 2008 loss from 86.1% to 88.1%, an increase of 2.3% that small employers pay as a result of the merger of the markets.

Note: Individual Post-Merger Products and Small Group make up the Merged Market Total. Individual Total is made up of Individual Pre-Merger and Individual Post-Merger Products. The proportion of premium dollars devoted to medical claims expenses for the individual segment, on average, is much higher than that of the small group segment . "Medical expense ratio" is the proportion of premium revenues devoted to medical claims expenses.

Examples of Premium Growth Variability: Results of Aging of Employees or Changes in Group Size

Scenario 1 – Company with 6 Employees	Rate Increase	Scenario 2 – Company with 20 Employees	Rate Increase
Rate increase if no change in employee composition (no employees age into higher age bands – Note: not probable for the average employer)	**6.0%**	Rate increase if no change in employee composition (no employees age into higher age bands – Note: not probable for the average employer)	**6.0%**
Rate increase if there is no change in employees; two employees age into next five-year age band	**10.2%**	Rate increase if there is no change in employees; six employees age into next five-year age band	**10.7%**
Rate increase if one employee of average age leaves the group, leaving the group with 5 members.	**15.8%**	Rate increase if three employees of average age leave the group, leaving the group with 17 members.	**6.1%**
Rate increase if one employee of average age leaves the group, resulting in a group of 5 employees AND a current employee ages from 29 years to 30 years	**17.6%**	Rate increase if three employees of average age leave the group, AND three current employees age from 24 to 25 years, 44 to 45 years, and 54 to 55 years	**9.2%**
Rate increase if one employee in early 60s retires and a 40-year-old replacement is hired	**-5.3%**	Rate increase if one employee retires and a 40-year-old replacement is hired	**1.5%**

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Massachusetts Health Care Cost Trends Final Report

Appendix C.4c

Health Care Cost Trends Public Hearings Presentations

Review of Analytic Findings from the Division of Health Care Finance and Policy: Privately Insured Medical Claims Expenditures

Deborah Chollet, Ph.D.,
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Privately Insured Health Spending Trends

March 2010

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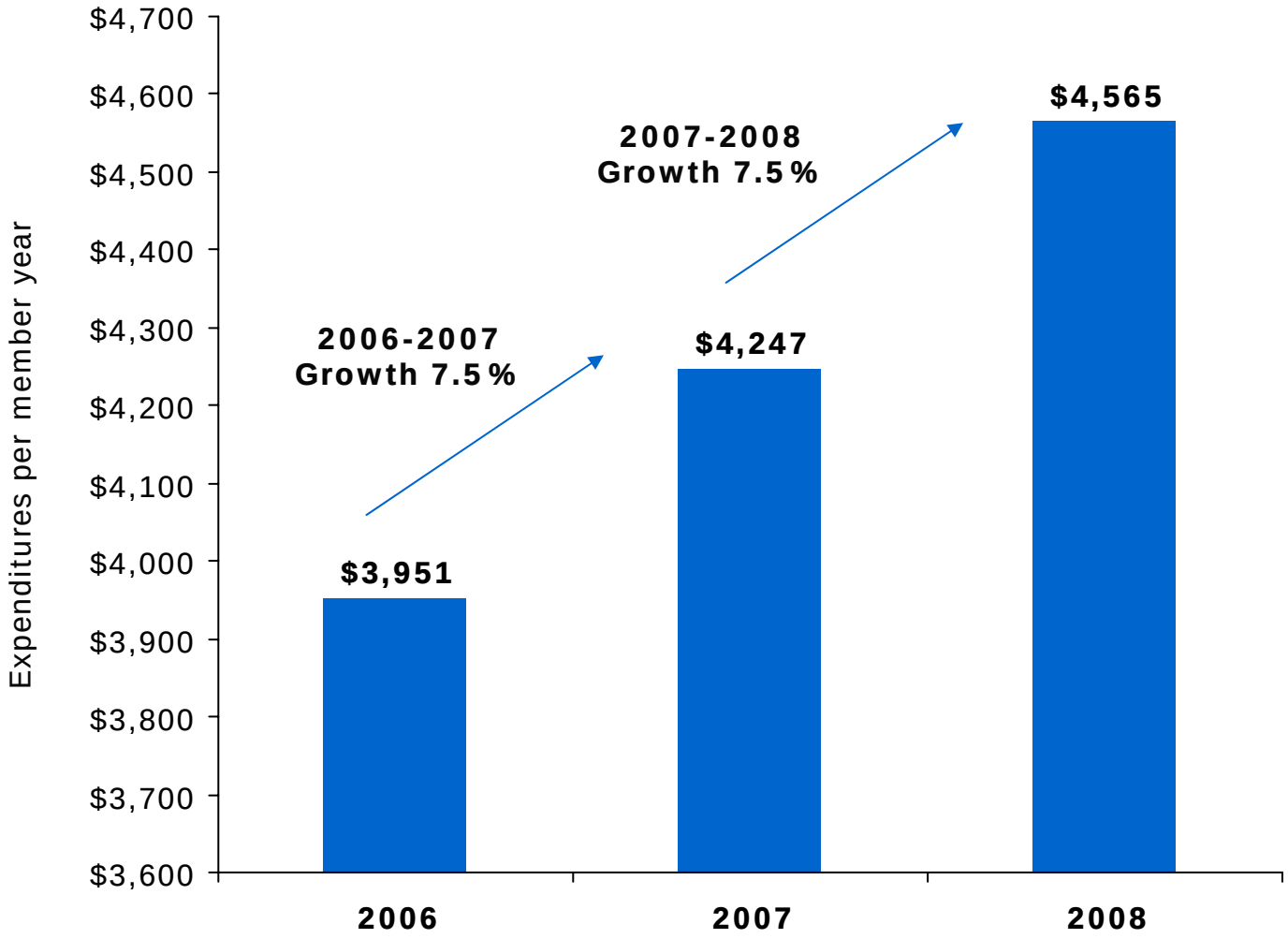
Division of Health Care Finance and Policy

Overview

- Spending for privately insured services per member year grew 7.5 percent per year from 2006 to 2008.
- Spending for outpatient hospital care and physician and other professional services grew faster than spending for other service types.
- Rising prices drove spending growth for inpatient hospital care and physician/professional services. Volume and price drove spending growth for outpatient services and for imaging.
- Prices vary widely for the same services—including hospital inpatient care, and outpatient and physician services.
- Hospital readmission is less likely when there is physician follow-up care after discharge.

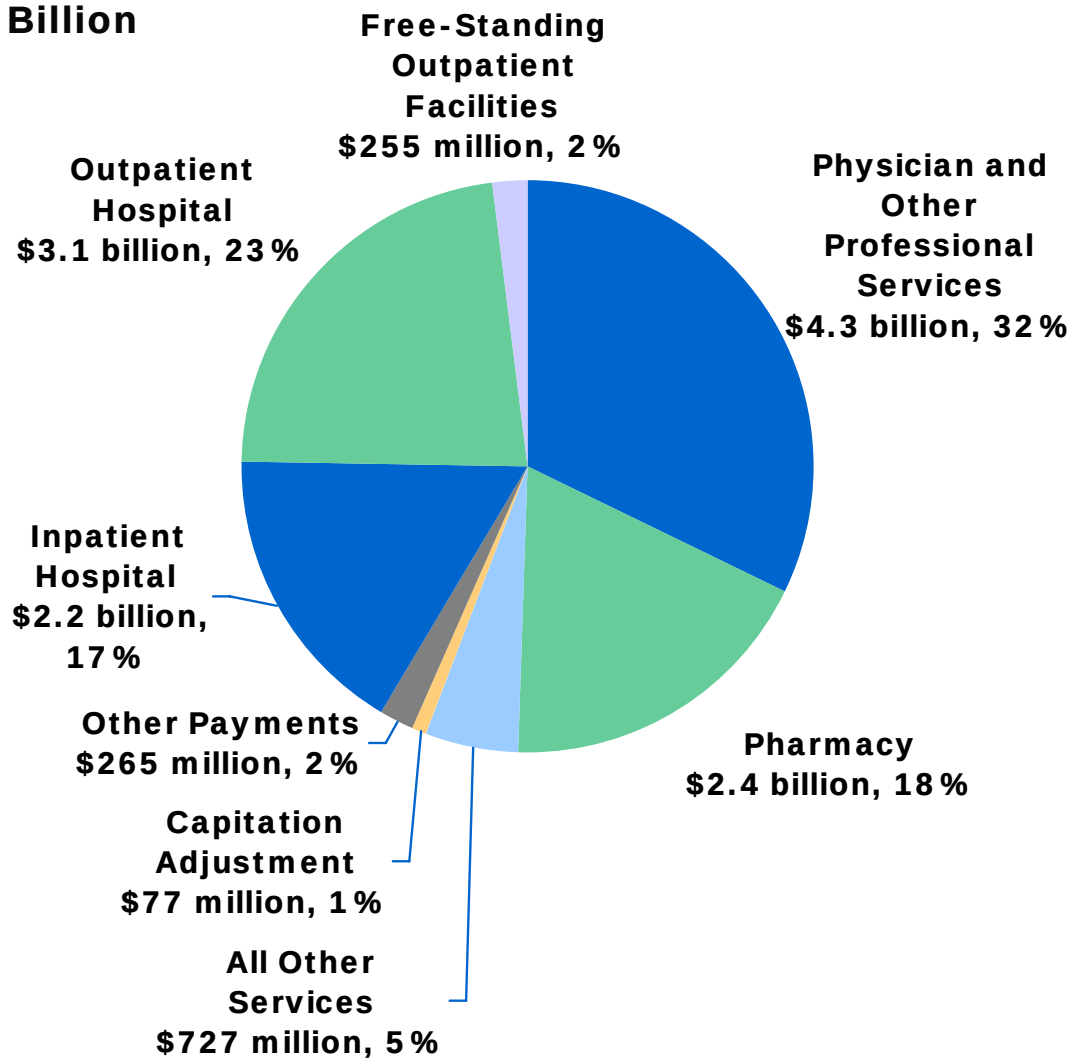
Expenditures per Member and Annual Growth: Privately Insured Health Care in MA



Health care spending grew 7.5% per member each year from 2006 to 2008—much faster than the national growth rate, 3.9% (net of cost sharing) from 2007 to 2008.

Distribution of Privately Insured Expenditures by Type of Service, 2008

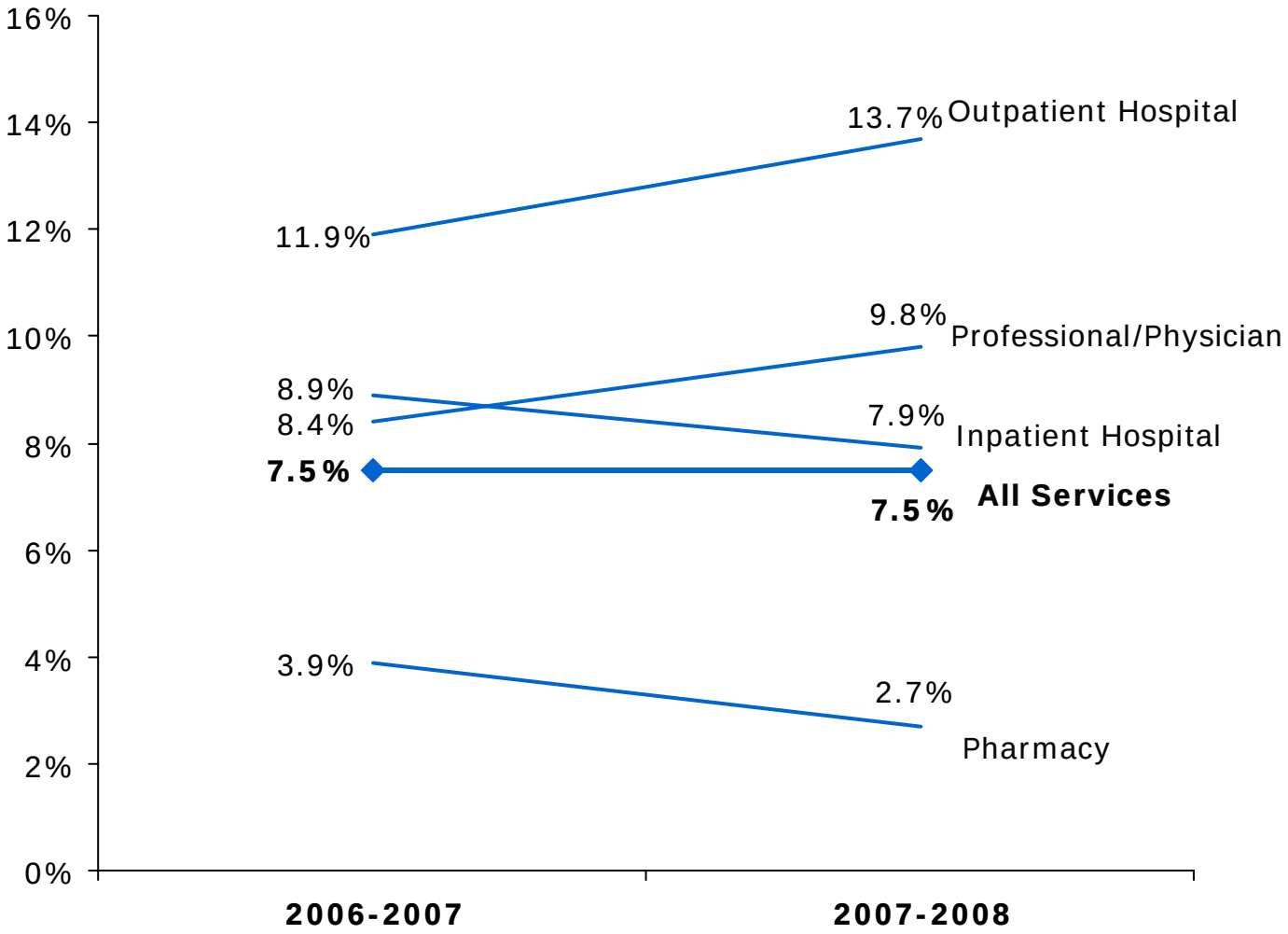
Total: $13.4 Billion



Professional services and outpatient facility services are the largest categories of spending, accounting for 57% of total spending for covered services.

Hospital inpatient care and pharmacy together account for another 35 percent of total spending for covered services.

Annual Growth in Privately Insured Expenditures per Member, by Major Type of Service



Spending for the largest categories of services—outpatient hospital services and physician/professional services—grew the fastest from 2007 to 2008, and at an increasing rate.

Spending for inpatient hospital care grew more slowly, but still 8-9 percent per year.

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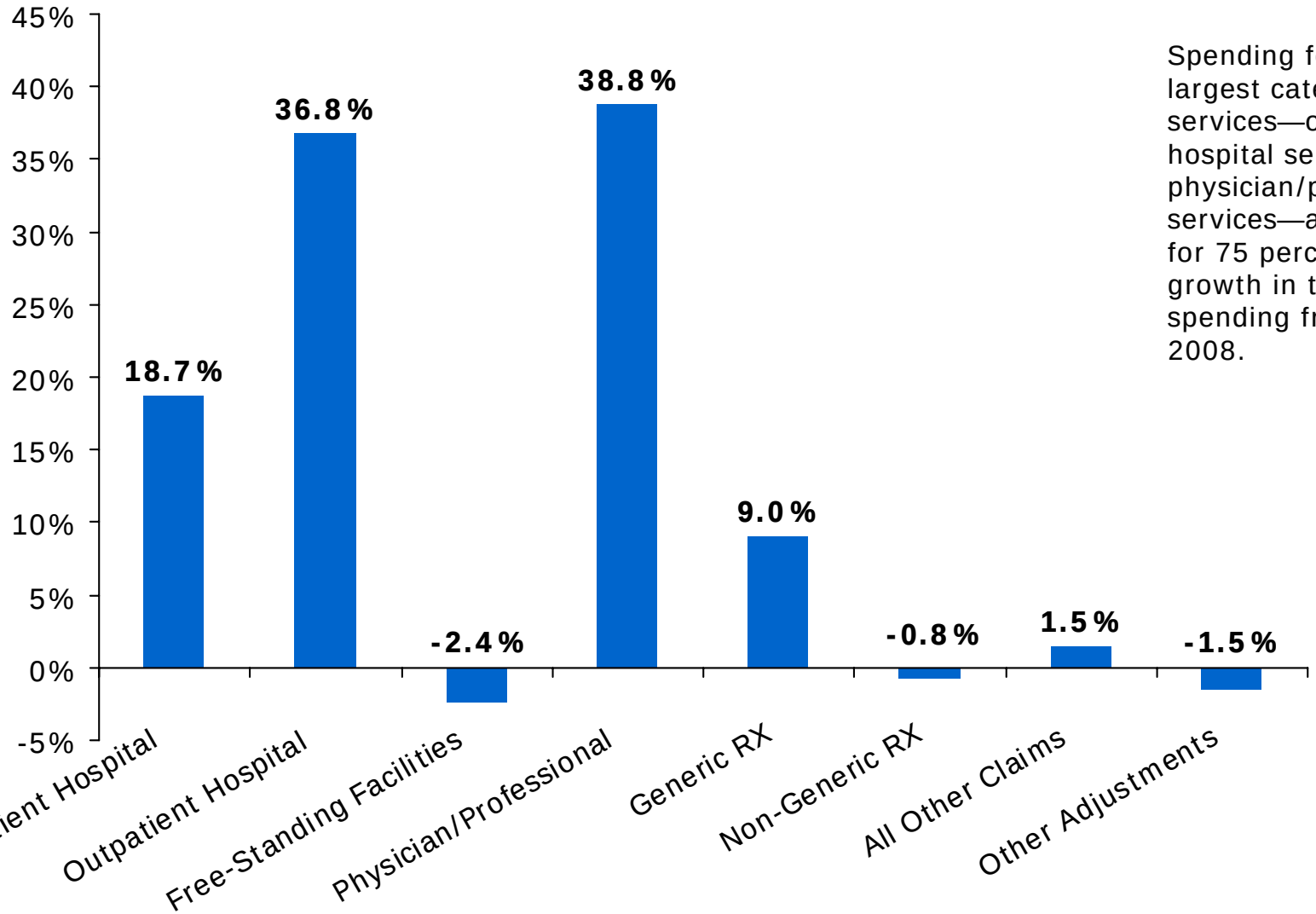
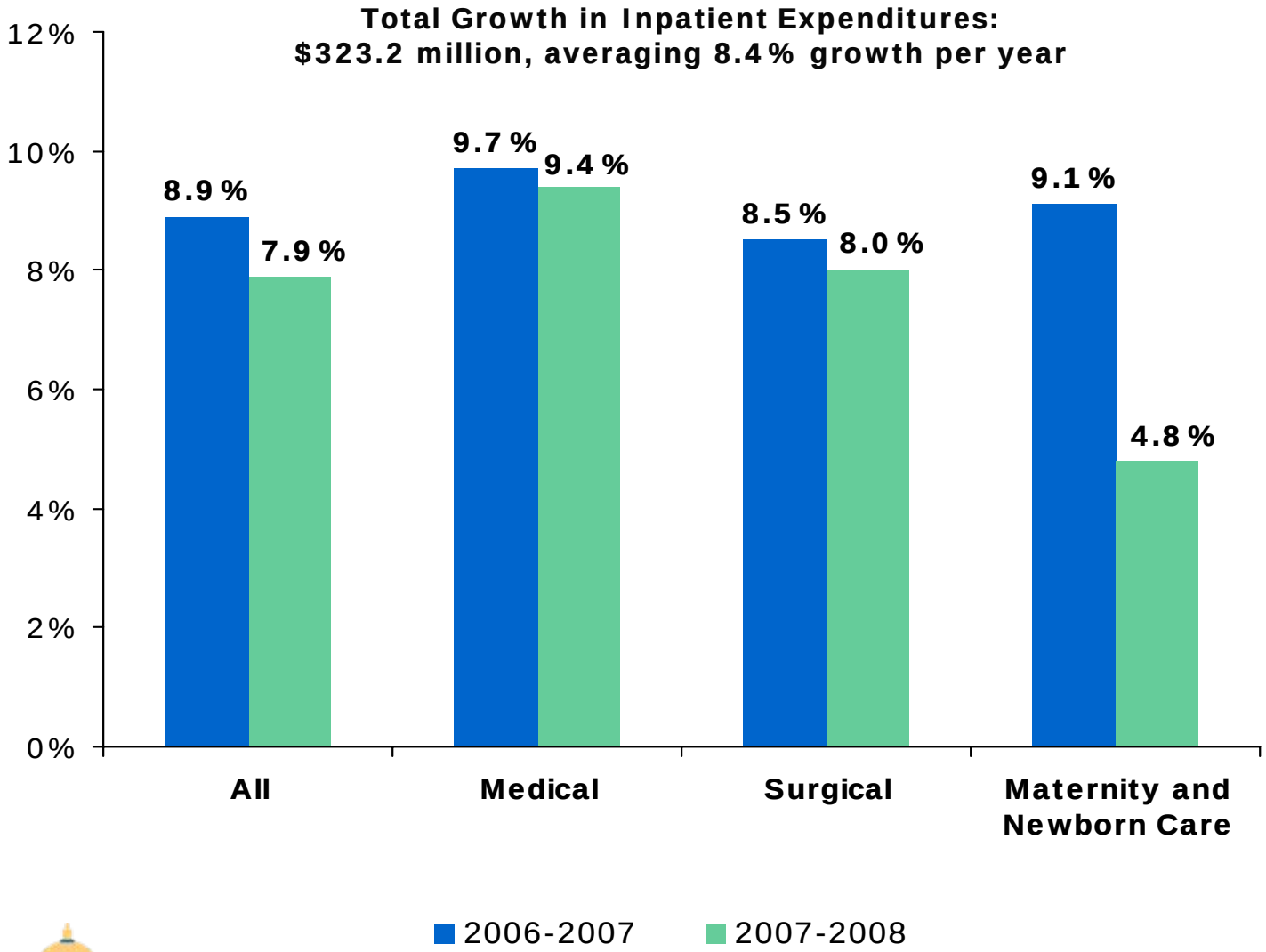
Contribution of Service Sectors to the Growth in Total Expenditure, 2006-2008



Spending for the largest categories of services—outpatient hospital services and physician/professional services—accounted for 75 percent of the growth in total spending from 2006 to 2008.

Hospital Inpatient Expenditures

Annual Growth in Inpatient Hospital Care per Member by Type of Service, 2006-2008



Spending for medical inpatient stays per member increased 9.4% to 9.7% each year, while spending for surgical inpatient stays increased 8.0 to 8.5%.

Slower growth in spending for maternity and newborn care slowed helped slow overall growth in spending for inpatient care.

Inpatient surgeries accounted for 52% of inpatient spending growth from 2006 to 2008. Inpatient medical spending accounted for 35%.

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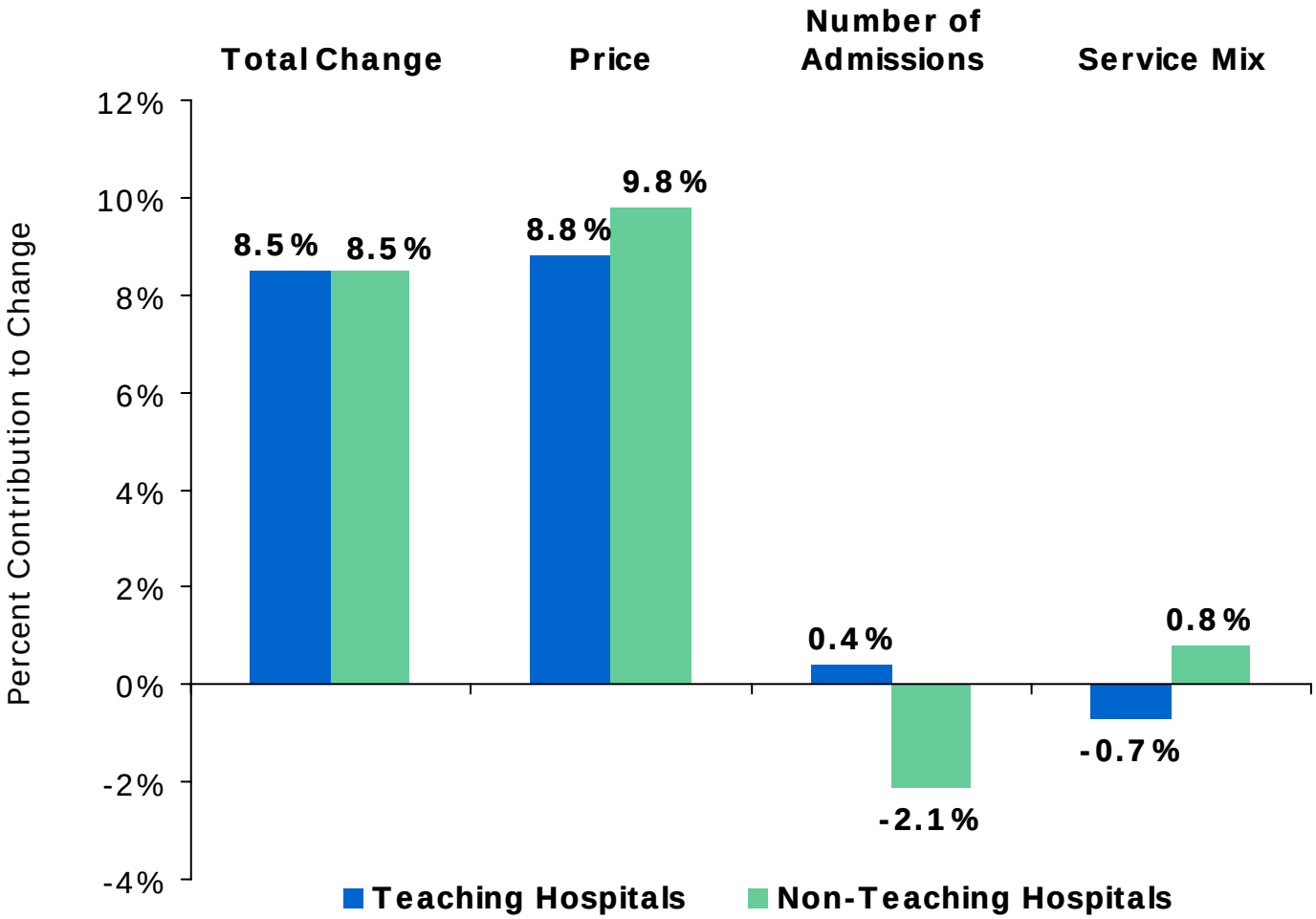
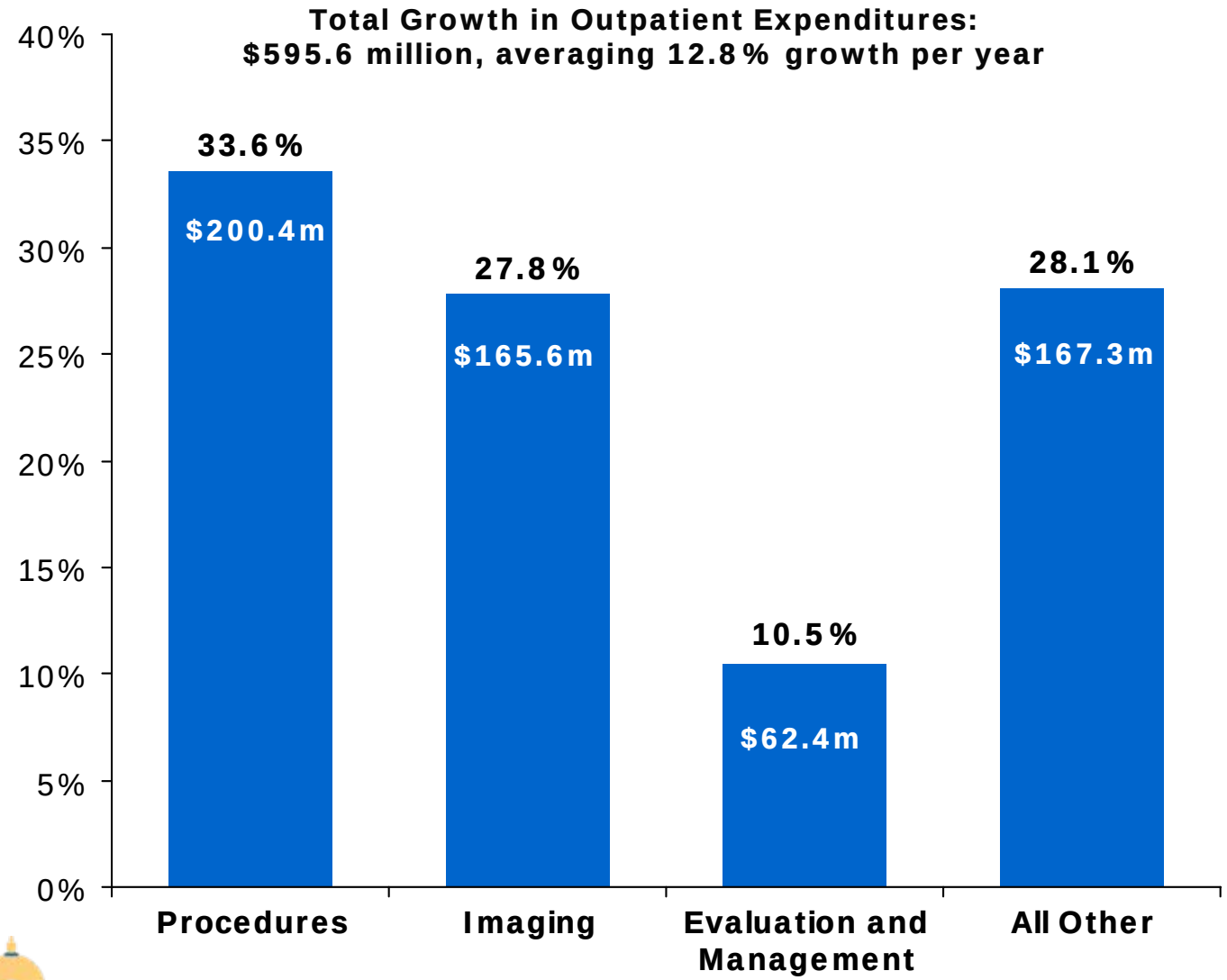
Drivers of Change in Total Hospital Inpatient Expenditures, 2006-2007



Rising prices were the dominant driver of growth in spending for inpatient services, for both teaching and non-teaching hospitals.

Expenditures for Outpatient Facility Services

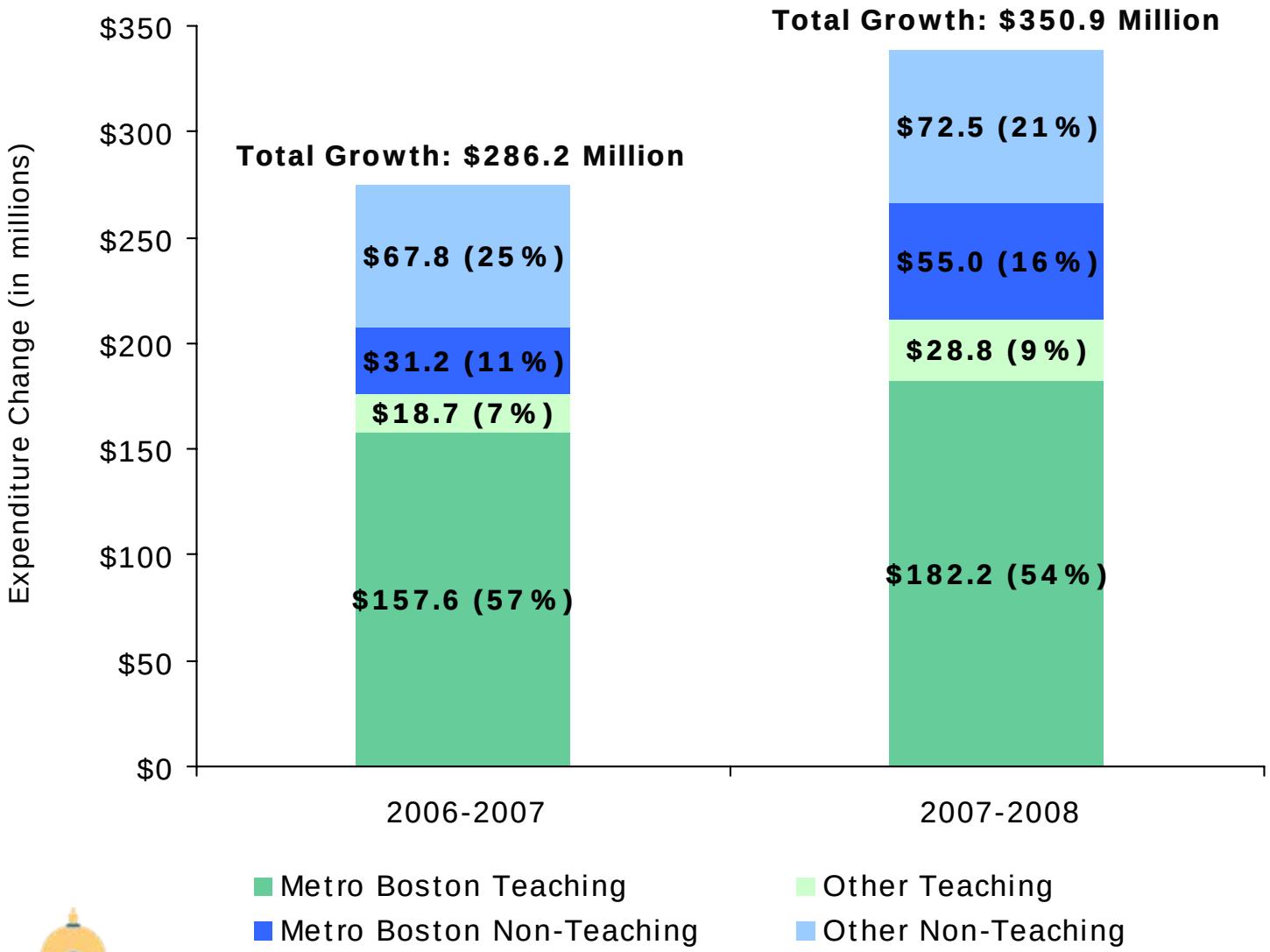
Contribution of Service Types to the Growth of Outpatient Facility Expenditures, 2006-2008



Spending for procedures grew by more than $200 million, accounting for 34% of outpatient expenditure growth.

Imaging grew $165 million, accounting for 28% of outpatient expenditure growth.

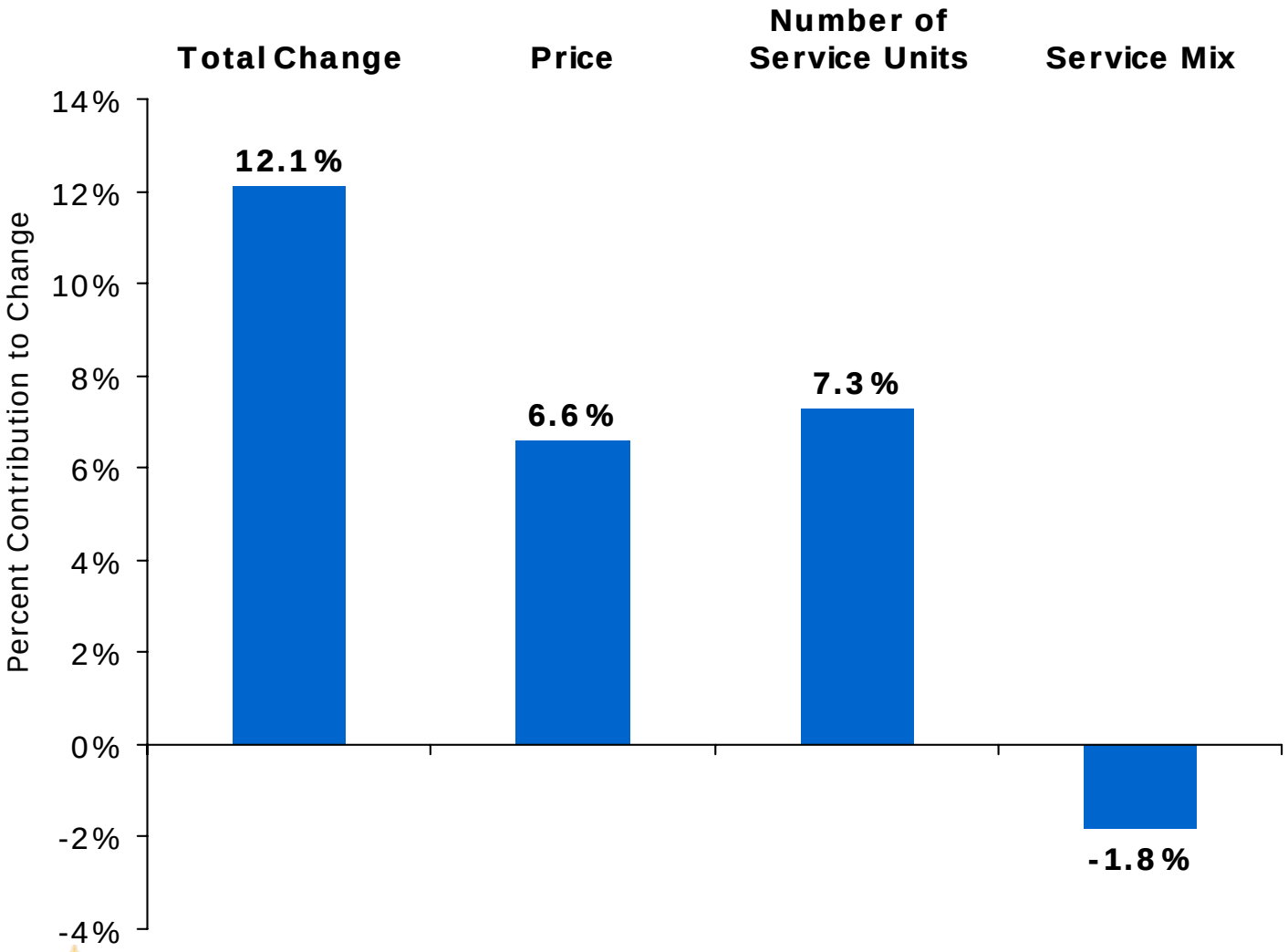
Distribution of Changes in Hospital Outpatient Expenditures by Teaching Status



Teaching hospitals accounted for 54% of total hospital outpatient spending in 2008 (not shown) but 63-64% of the growth in spending for outpatient services each year.

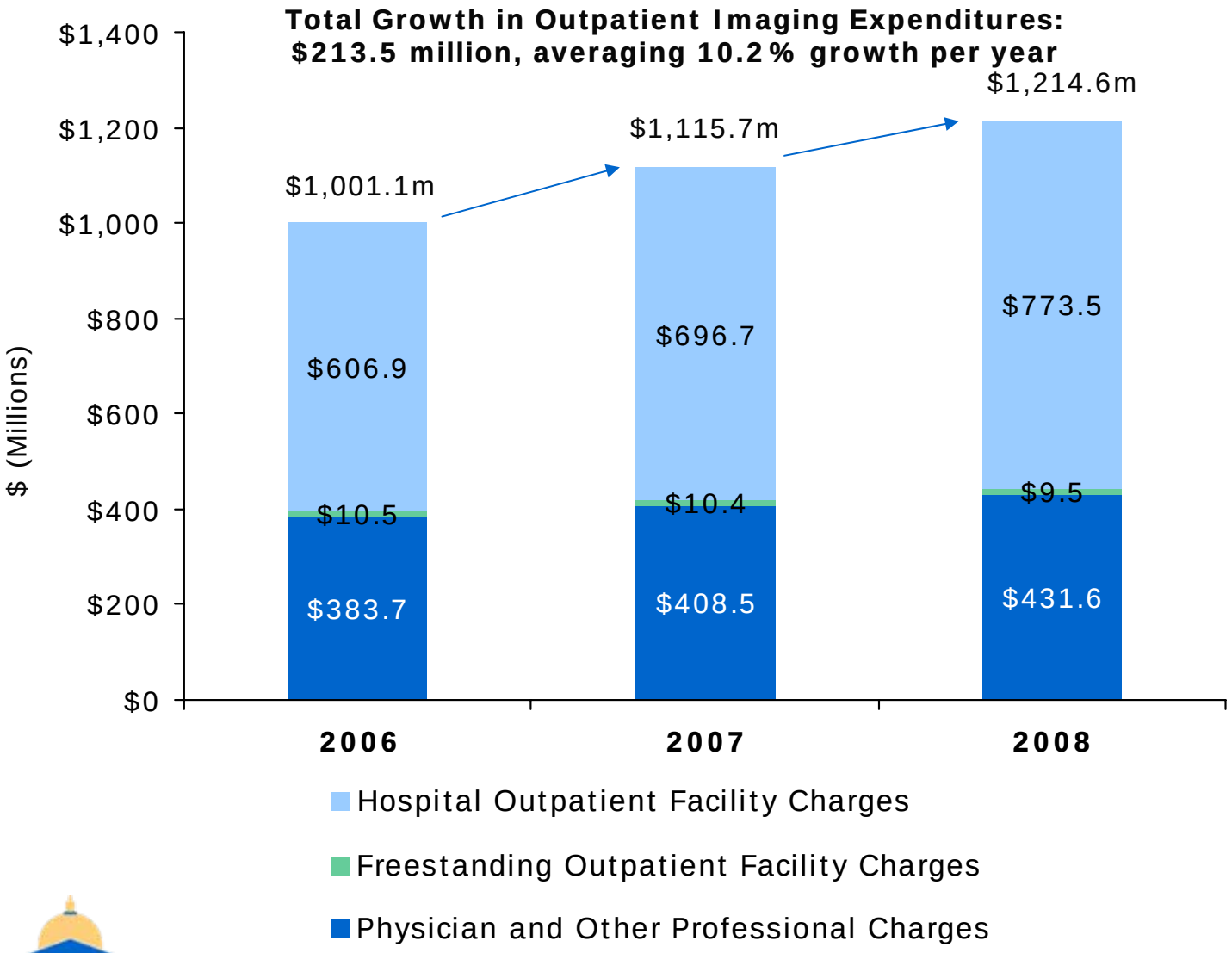
DHCFP

Drivers of Change in Outpatient Service Expenditures, 2006-2007



Both volume and price contributed to the growth in spending for outpatient facility care.

Growth in Total Outpatient Imaging Expenditures by Provider Type, 2006-2008

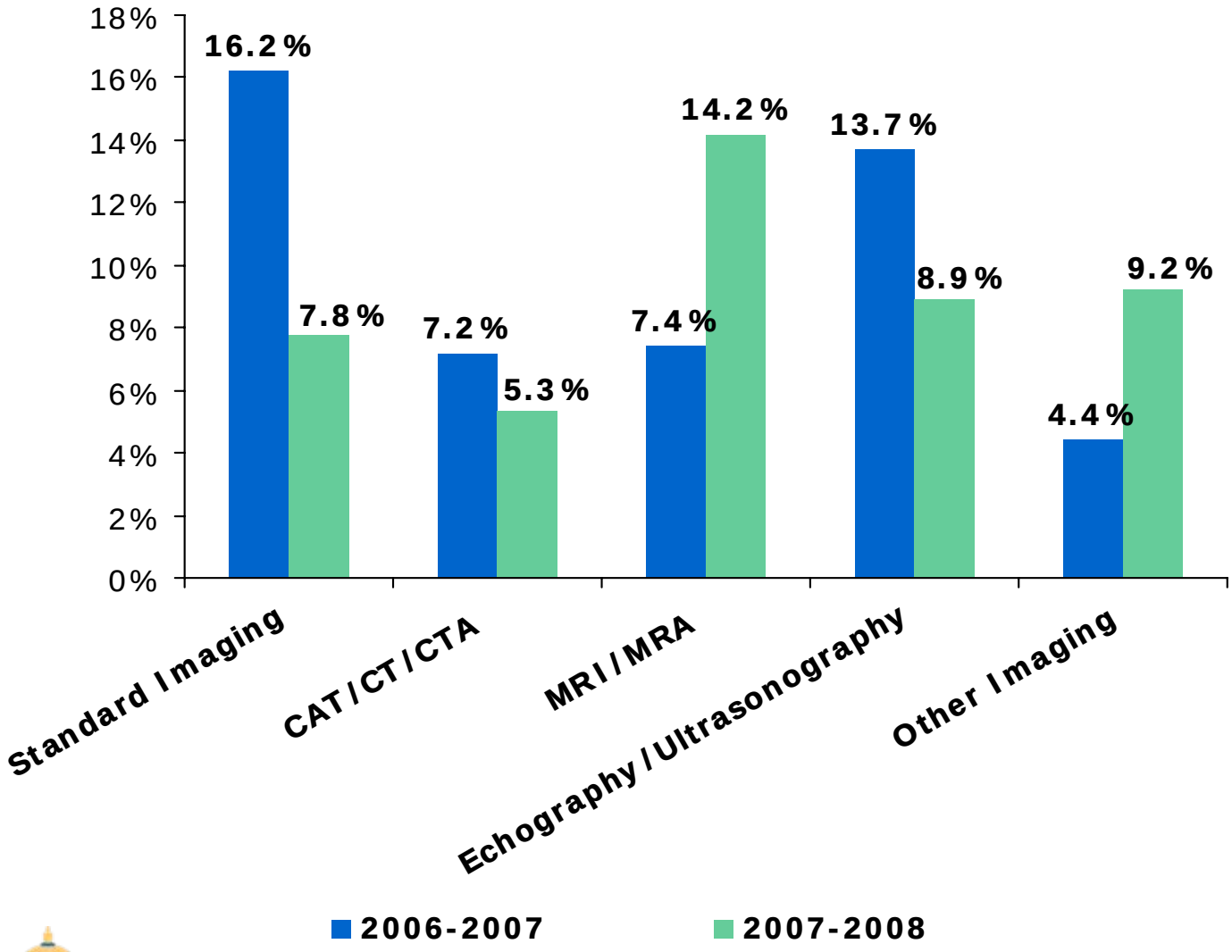


Spending for outpatient imaging services grew 21% from 2006 to 2008.

Facility charges (nearly entirely from acute care hospitals) accounted for two-thirds of all spending for outpatient imaging services, and grew 27.5%.

Professional charges accounted for 36% of total spending for outpatient imaging services, and grew 12.5%.

Annual Growth in Outpatient Imaging Expenditures by Type of Service

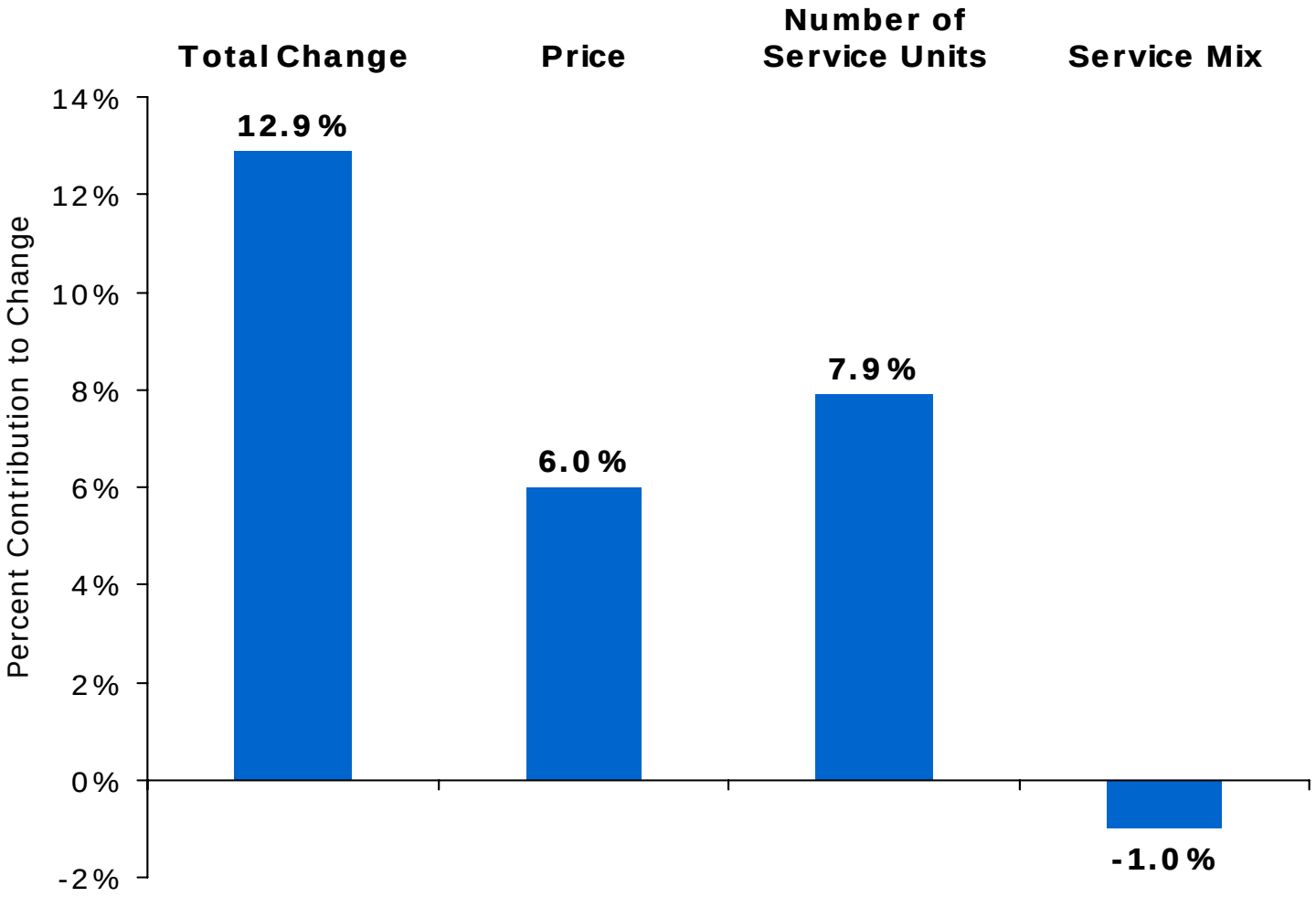


Standard imaging is the largest single component of imaging expenditures.

Spending for standard imaging grew fastest from 2006 to 2007, followed by echography and ultrasound.

MRI/MRA grew fastest from 2007 to 2008.

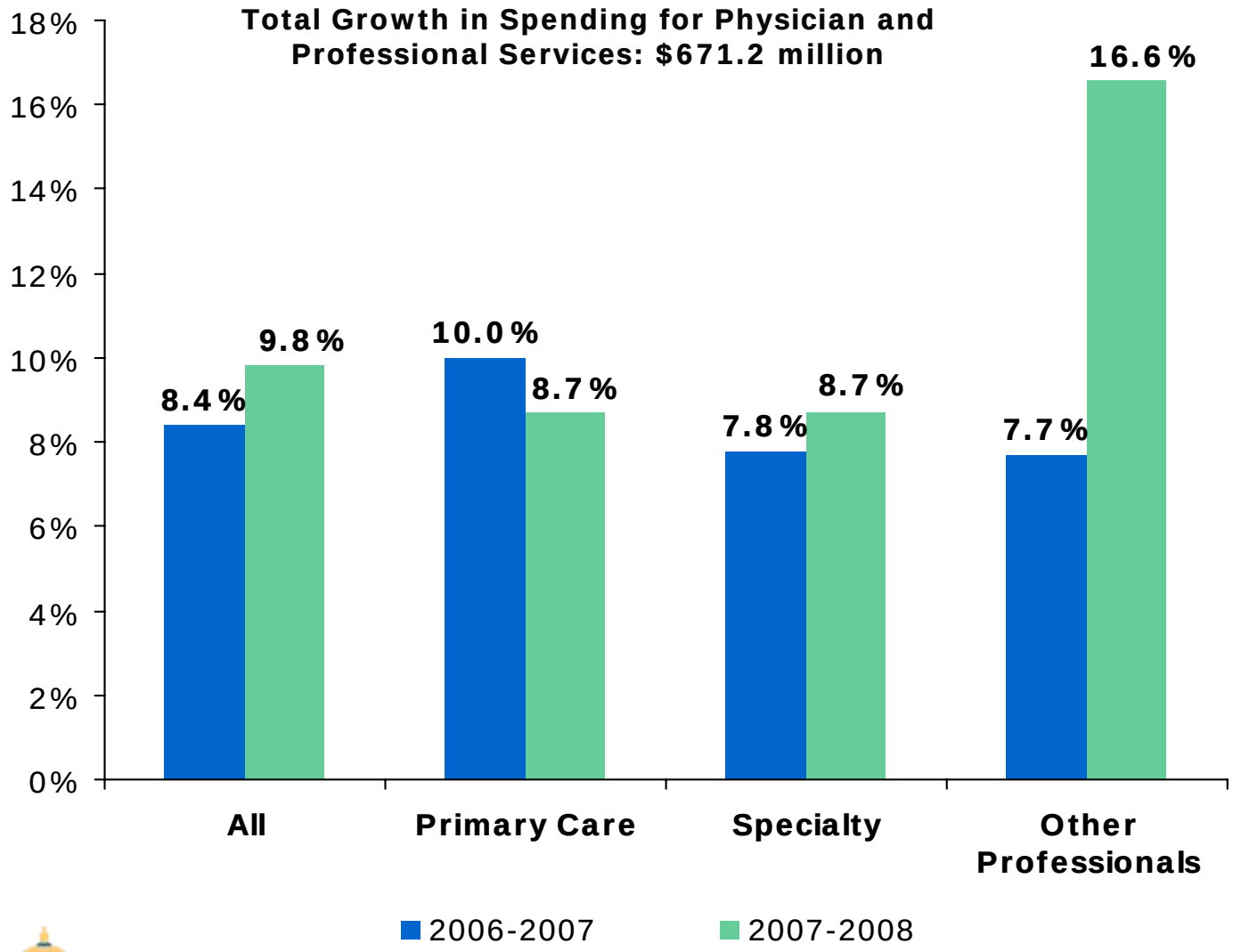
Drivers of Change in Imaging Service Expenditures, 2006-2007



Both volume and price drove growth in spending for imaging services from 2006 to 2007.

Physician and Other Professional Services Expenditures

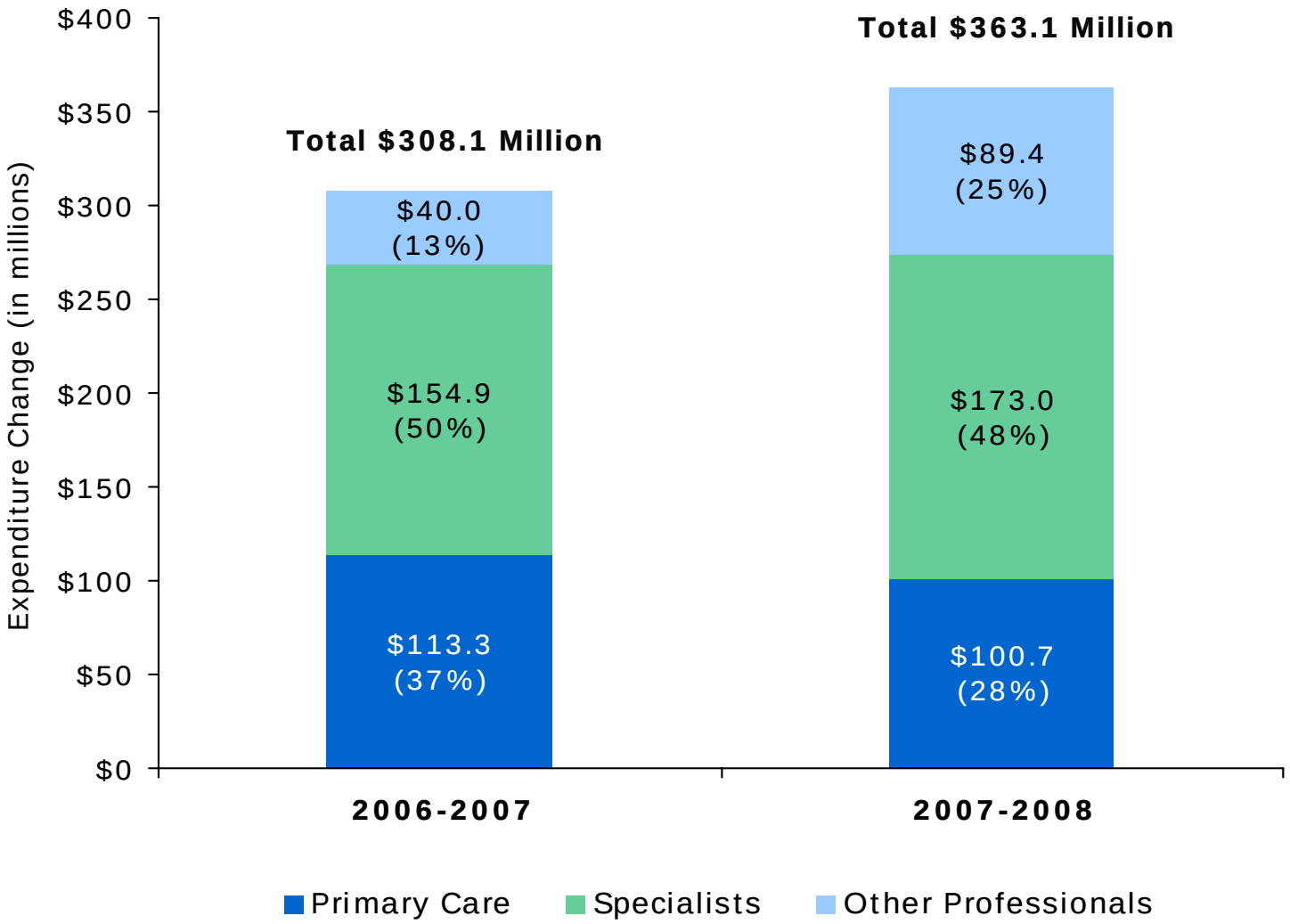
Annual Growth in Physician/Professional Services per Member by Provider Type



Faster growth in spending for physician services reflected faster growth in spending for specialists and other professionals such as nurses, therapists, psychologists, and dentists.

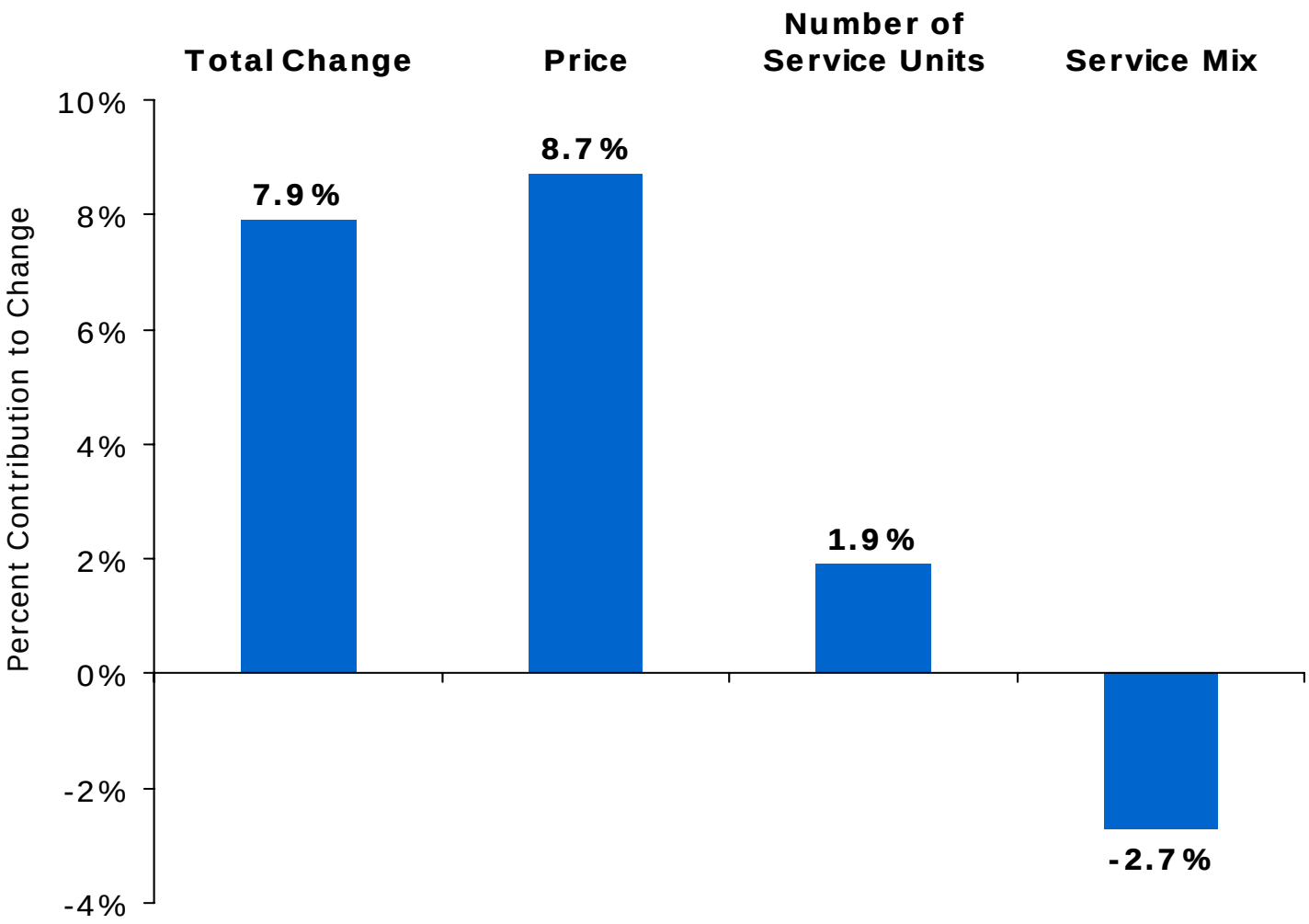
Spending for primary care services slowed.

Contribution of Provider Type to Annual Growth of Physician/Professional Expenditures



Spending for specialist services accounted for about half of the growth in total spending for physician/professional services from 2006 to 2008.

Drivers of Change in Physician/Professional Service Expenditures, 2006-2007

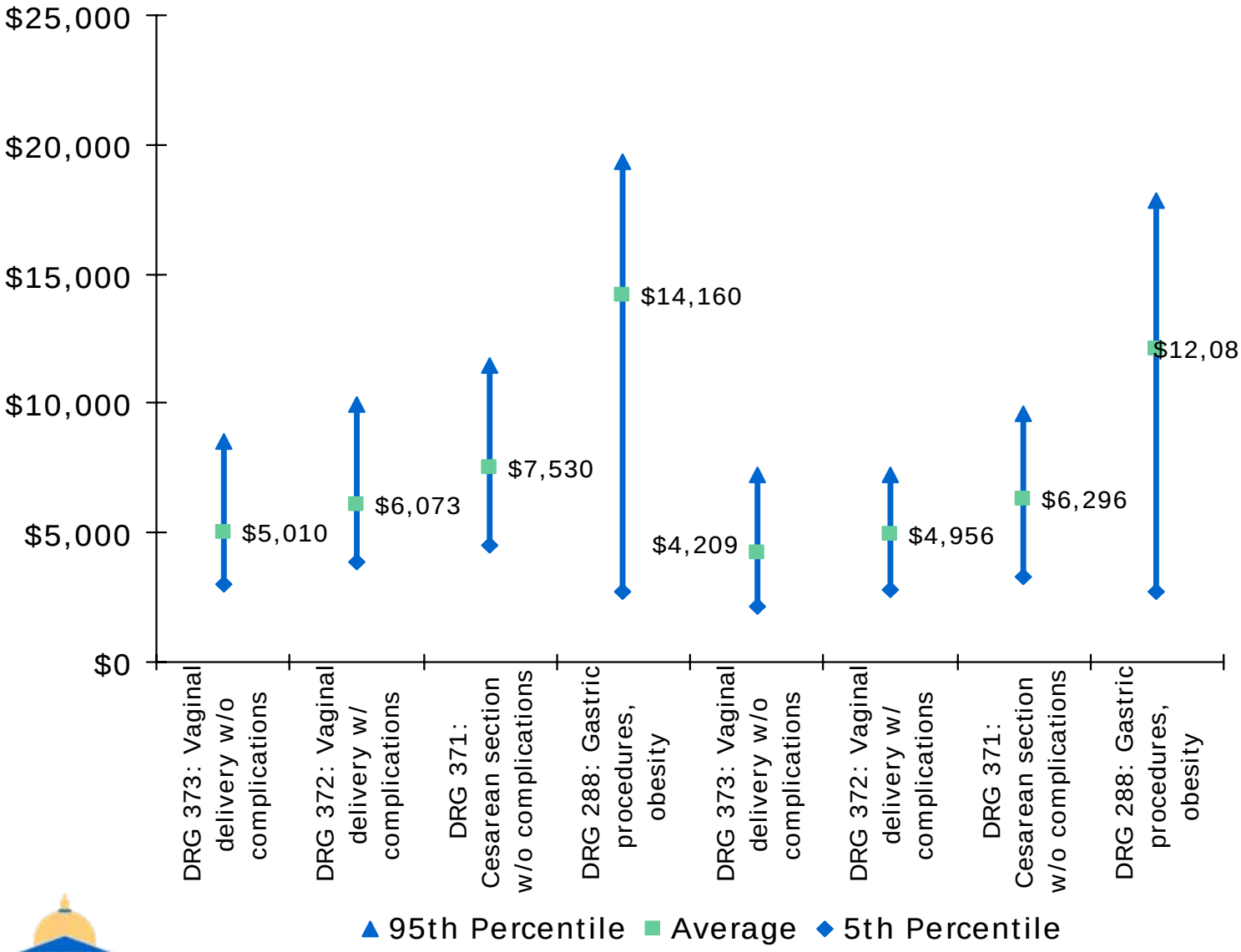


Prices drove most of the increase in spending in spending for physician/ professional service expenditures.

Opportunities for Improving Efficiency

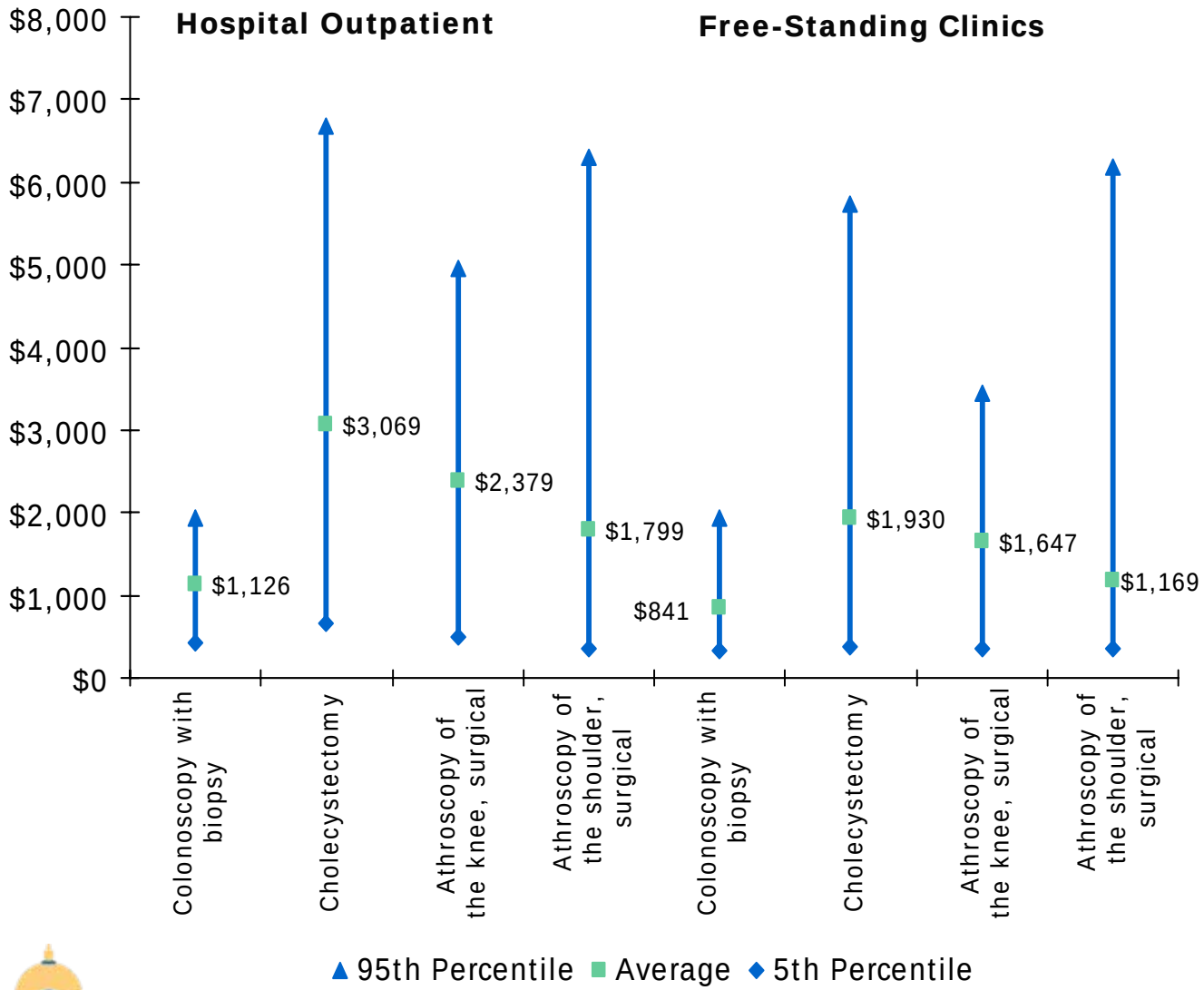
- Price variation for inpatient, outpatient, physician, and imaging services
  - Provider market power, failure of competition
  - Opportunities for insurers, employers, and patients to choose more efficient providers
- Avoidable hospital readmissions
  - Readmissions add to premium costs; some might be avoided
  - Opportunities to avoid readmissions by improving post-discharge care

Price Variation for Selected High-Frequency Inpatient DRGs, 2008



Prices for common inpatient procedures varied widely—for example, by more than 2:1 for common maternity diagnoses, and 5:1 for gastric procedures for obesity.

Price Variation for Selected High-Frequency Outpatient Services by Outpatient Facility, 2008

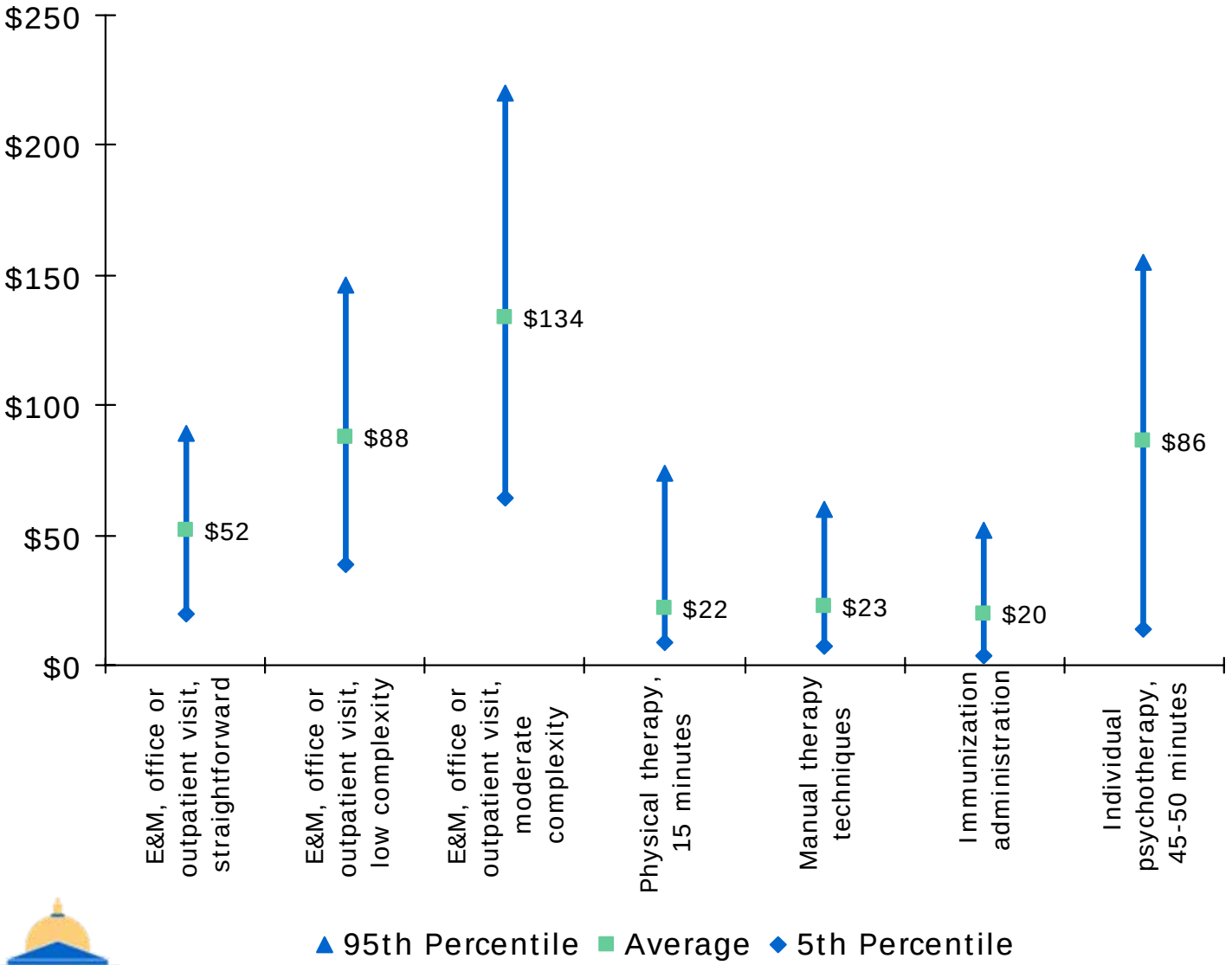


Prices varied widely for care in both hospital outpatient settings and free standing clinics.

For example, for arthroscopic knee surgery, the highest price (at the 95th percentile) was more than twice the average price. For arthroscopic shoulder surgery, the highest price was 3 to 5 times the average.

Prices for other high-frequency hospital-based serves—inpatient care and outpatient imaging—also varied widely.

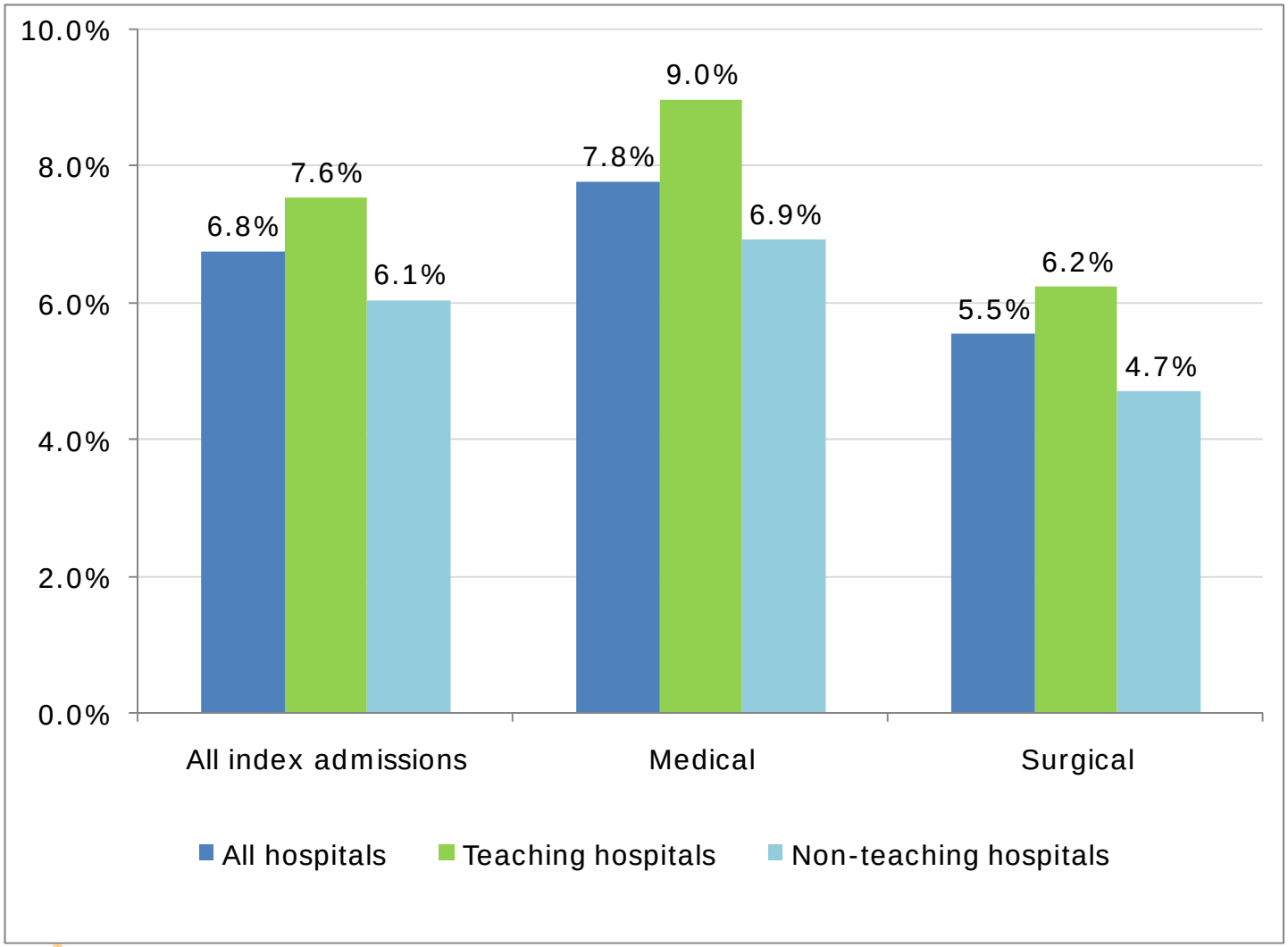
Price Variation for Selected High-Frequency Physician/Professional Services, 2008



In 2008, the highest price (95th percentile) for an evaluation and management visit was almost twice the average price paid (5th percentile).

Prices for other physician and professional services also varied widely.

Percent of Index Admissions that Resulted in Readmission Within 30 Days, 2007

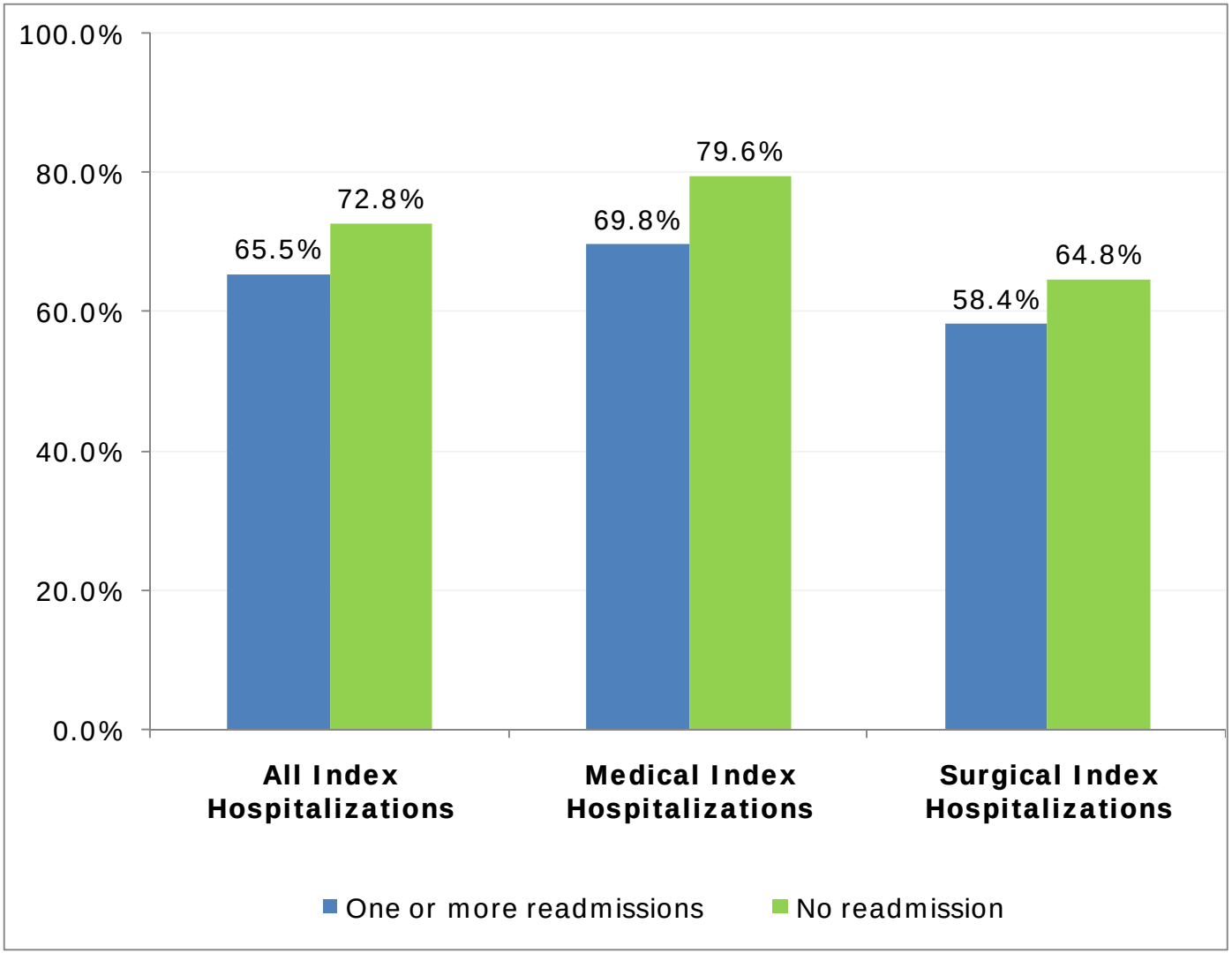


Nearly 7 percent of privately insured admissions were followed by readmission (all causes) within 30 days.

Unadjusted for risk, the average readmission rate is higher for teaching than nonteaching hospitals.

The total cost of readmissions was $49 per member year; 63% of this amount was associated with teaching hospitals.

Percent of Index Admissions with a Physician Visit within 30 Days, 2007



Privately insured patients who were readmitted were less likely to have seen a physician within 30 days after discharge.

These differences were found for teaching and nonteaching hospitals, and were greater for the DRGs that accounted for the most readmissions.

Massachusetts Health Care Cost Trends Final Report

Appendix C.4d

Health Care Cost Trends Public Hearings Presentations

Expert Witness: "Why Doing Nothing Is NOT An Option" Len Nichols, Ph.D., George Mason University

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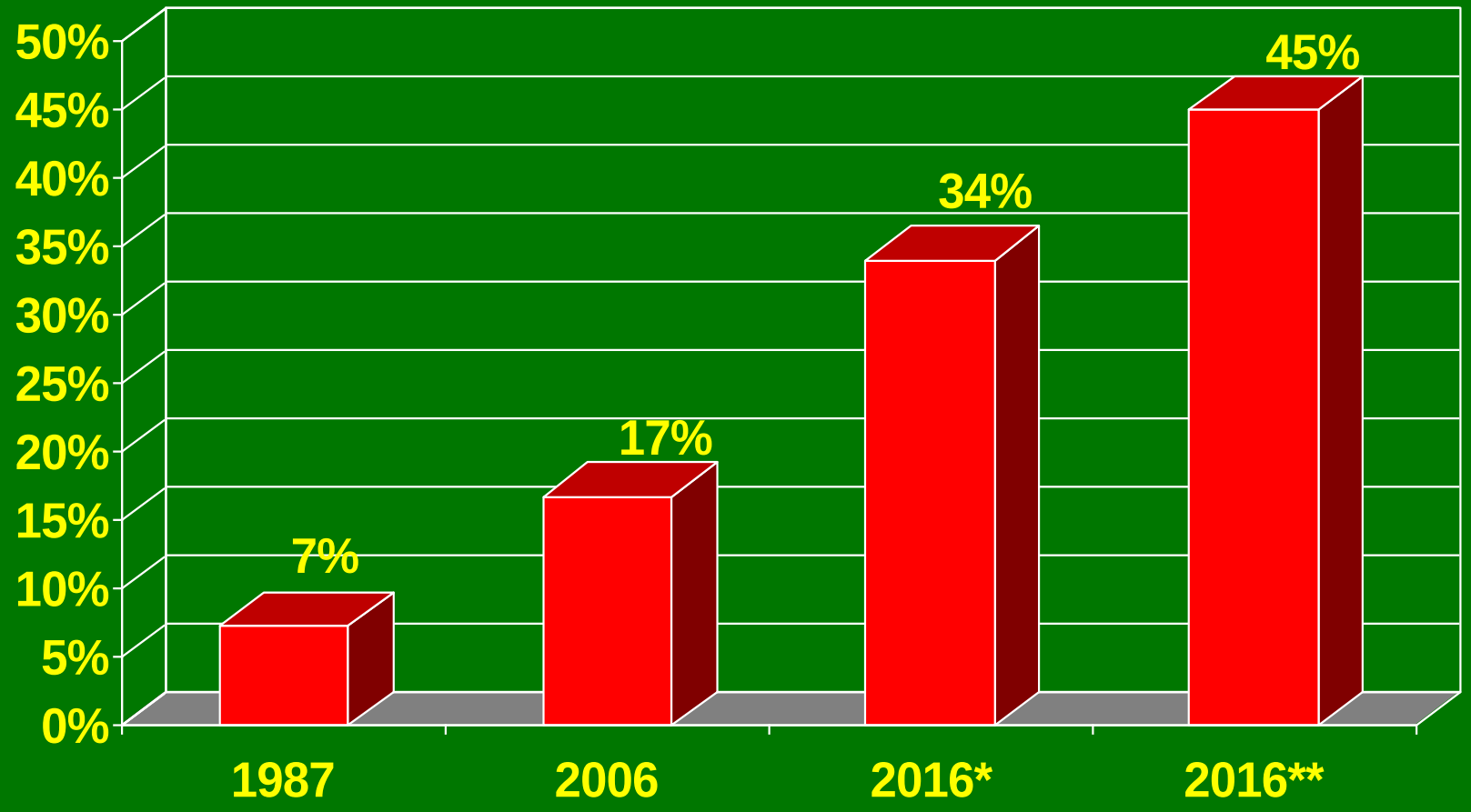
Why Doing Nothing Is NOT An Option

Len Nichols, Ph.D.
Director, Center For Health Policy Research and Ethics
College of Health And Human Services
George Mason University

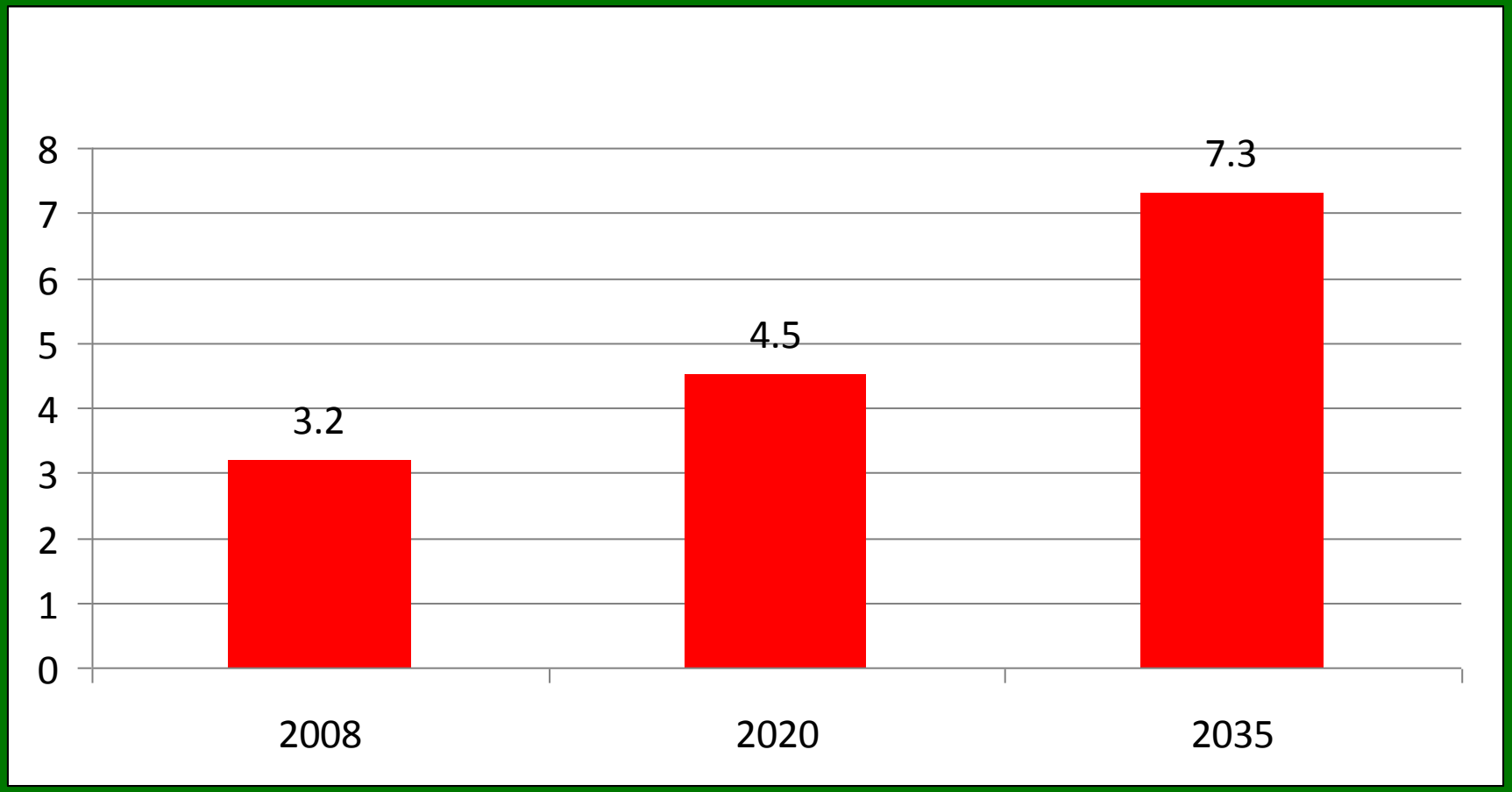
Division of Health Care Finance and Policy
Annual Public Hearing under M.G.L. c.118G §6 ½
March 16, 2010
Boston, MA

Percent of median family income required to purchase family health insurance

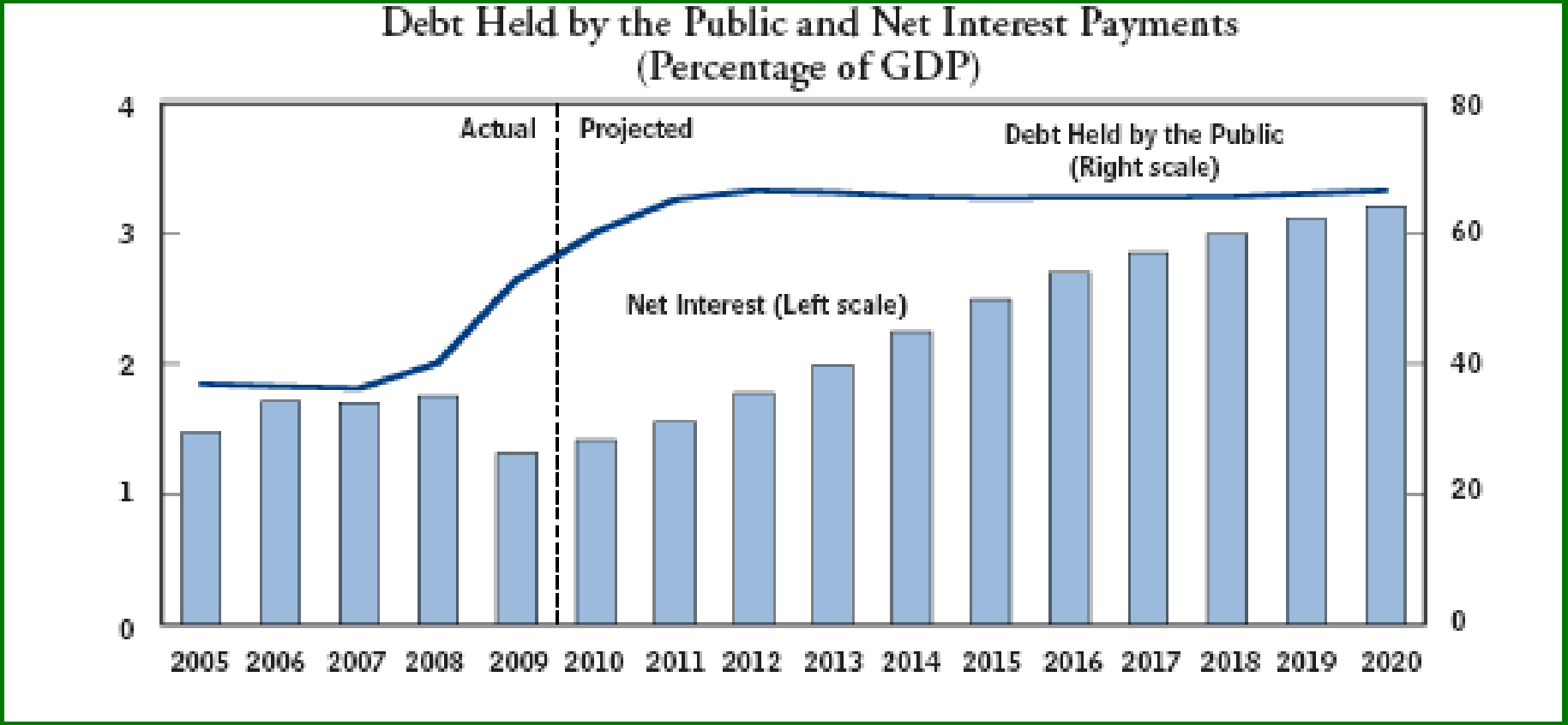


Source: Author's calculations, using KFF and AHRQ premium data, CPS income data, plus projections from Carpenter and Axeen, The Cost of Doing Nothing, 2008.

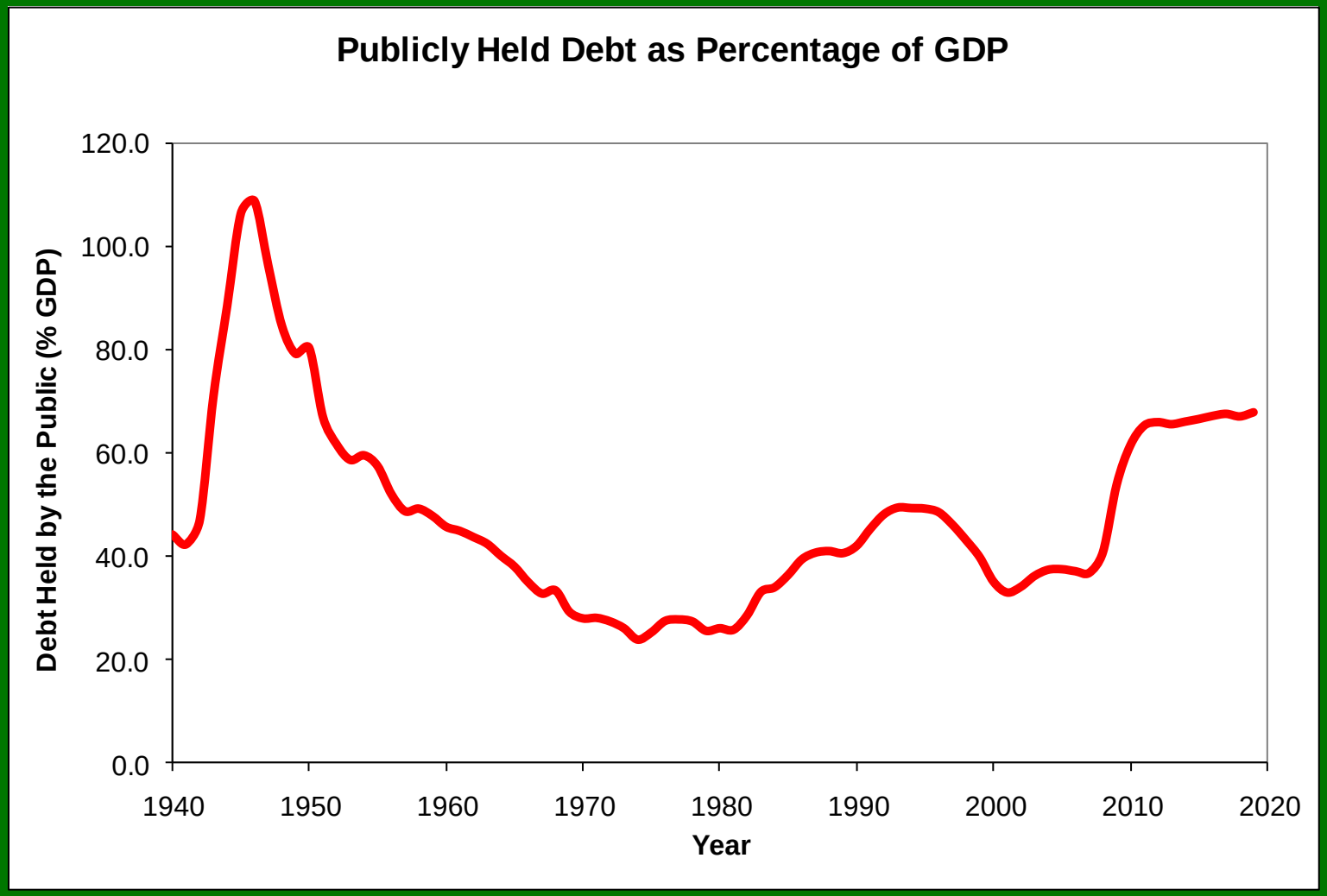
Medicare is unsustainable now (percent of GDP, projected)



Source: Medicare Trustees Report:, 2009.



Source: Congressional Budget Office



Source: Council of Economic Advisors, CBO.

Take Away Messages

- Local Market Power is major issue
  - Countervailing market (buying) power may be best, along with serious transparency
- Elements of Countervailing Market Power
  - Signal business as usual is over
  - Ending FFS is not enough
  - LISTEN to progressive private sector voices
- Private Sector Voices Tell Me:
  - Evidence based regulation
  - Share information and incentives will all payers
  - Reward clear objectives clearly and swiftly
  - Make public-private partnership to teach best practices

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Professor of Health Policy
College of Health and Human Services

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E-mail: lnichol9@gmu.edu
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Massachusetts Health Care Cost Trends Final Report

Appendix C.4e

Health Care Cost Trends Public Hearings Presentations

Review of Findings from Investigation into Health Care Cost Trends and Cost Drivers
Martha Coakley
Massachusetts Attorney General

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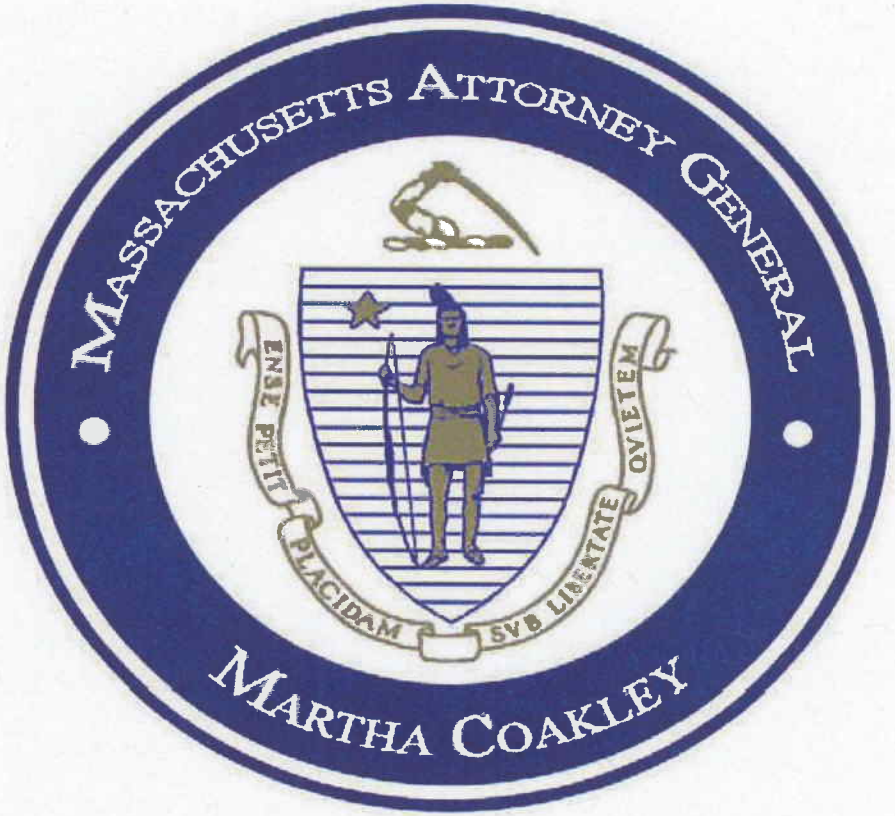


REPORT ON EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. c. 118G, § 6½(b)

OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY
ONE ASHBURTON PLACE • BOSTON, MA 02108

MARCH 16, 2010

AGO EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS

- Massachusetts is a national leader in health care access and fortunate to have exceptional health care quality.
- To preserve access and quality, we must also be a leader in promoting affordability.
- This hearing is a unique opportunity to provide health care cost transparency.

OUR REVIEW AND ANALYSIS

- Identified prices paid for health care and how those prices are determined.
- After identifying disparate prices for similar services, sought to explain those differences:
  - Quality
  - Patient population
  - Complexity of services
- Market Leverage usually drives prices.

OUR REVIEW SHOWED

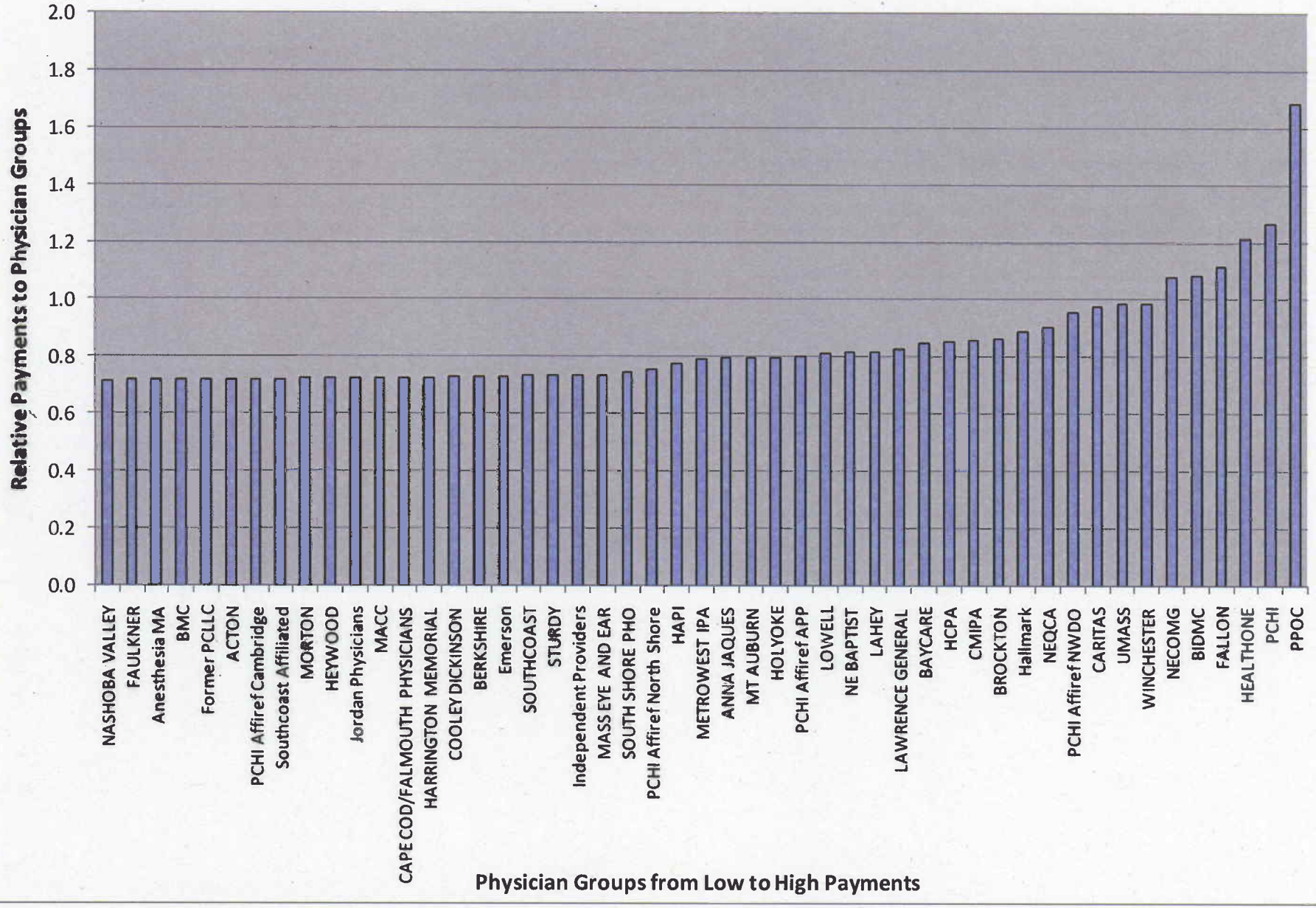
1. Prices paid to hospitals and physician groups vary significantly.
2. Higher prices are not tied to quality, complexity, proportion of government patients, or academic status.
3. Prices are correlated to market leverage.
4. Total medical expenses do not correlate to payment method with TME sometimes higher for risk-sharing providers.

FINDINGS CONT'D

5. Price increases, not increases in utilization, caused most of the increases in health care costs in the past few years.
6. More expensive providers are gaining market share at the expense of less expensive providers.
7. The health care market has been distorted by contracting practices that reinforce and perpetuate disparities in pricing.

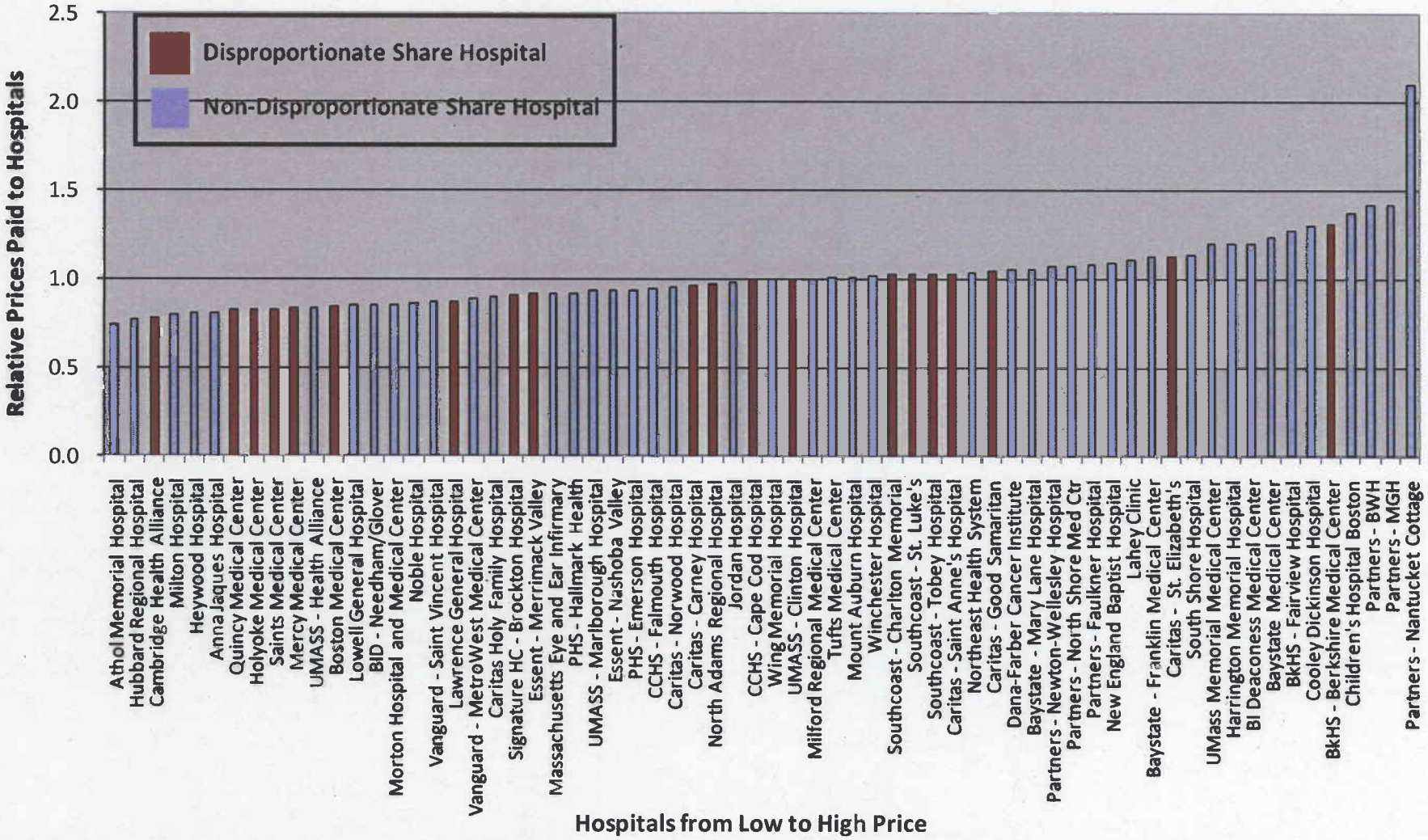
The following are select slides from the AGO's Report for this Annual Public Hearing. Each is based on data provided by a major insurer and is presented to illustrate one or more of our key findings.

PRICES FOR PHYSICIANS VARY SIGNIFICANTLY



INFORMATION FROM A MAJOR HEALTH PLAN: FOR ILLUSTRATIVE PURPOSES ONLY

PRICES FOR HOSPITALS VARY SIGNIFICANTLY

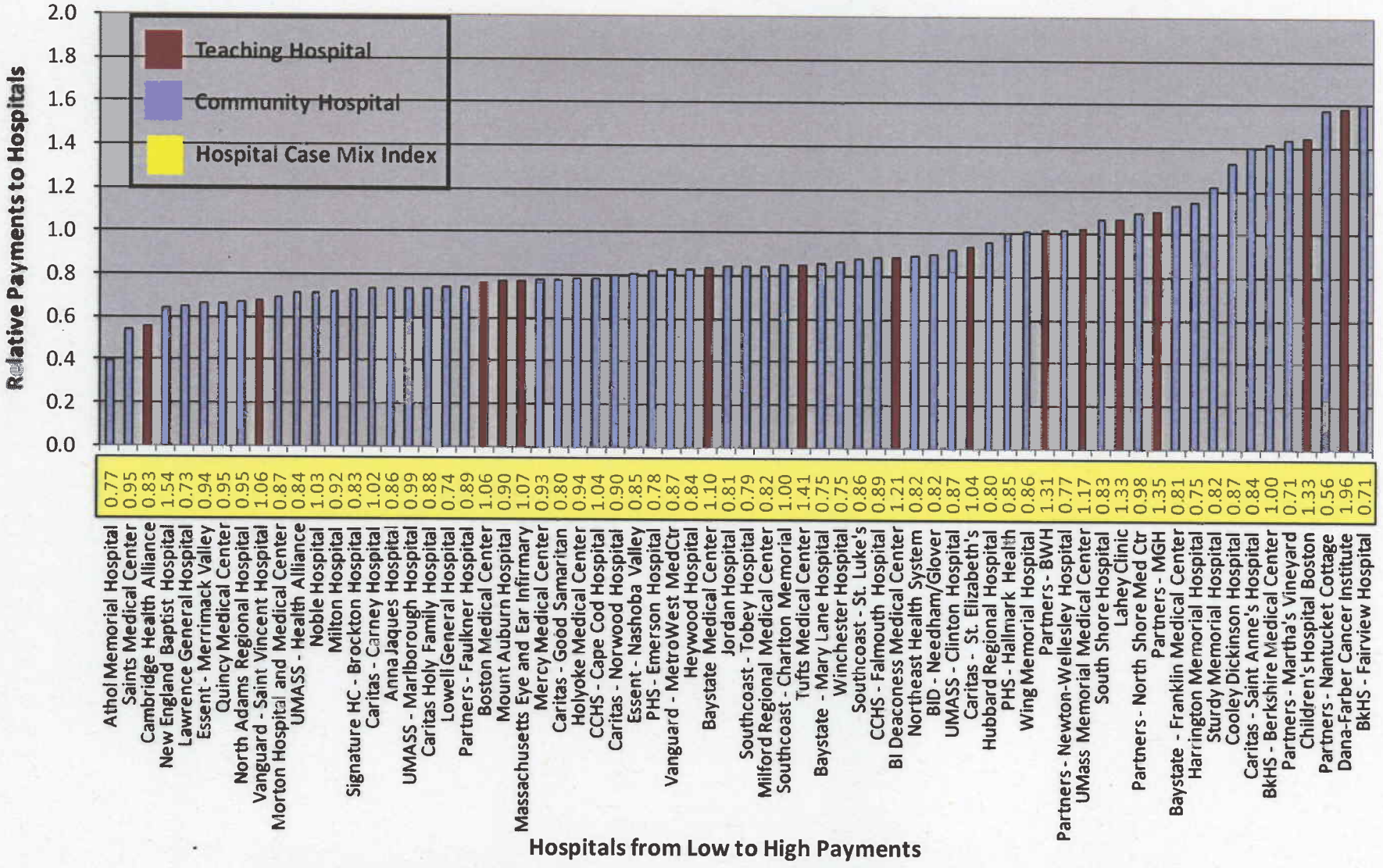


HIGHER PRICES ARE NOT TIED TO PROPORTION OF GOVERNMENT PATIENTS

INFORMATION FROM A MAJOR HEALTH PLAN: FOR ILLUSTRATIVE PURPOSES ONLY

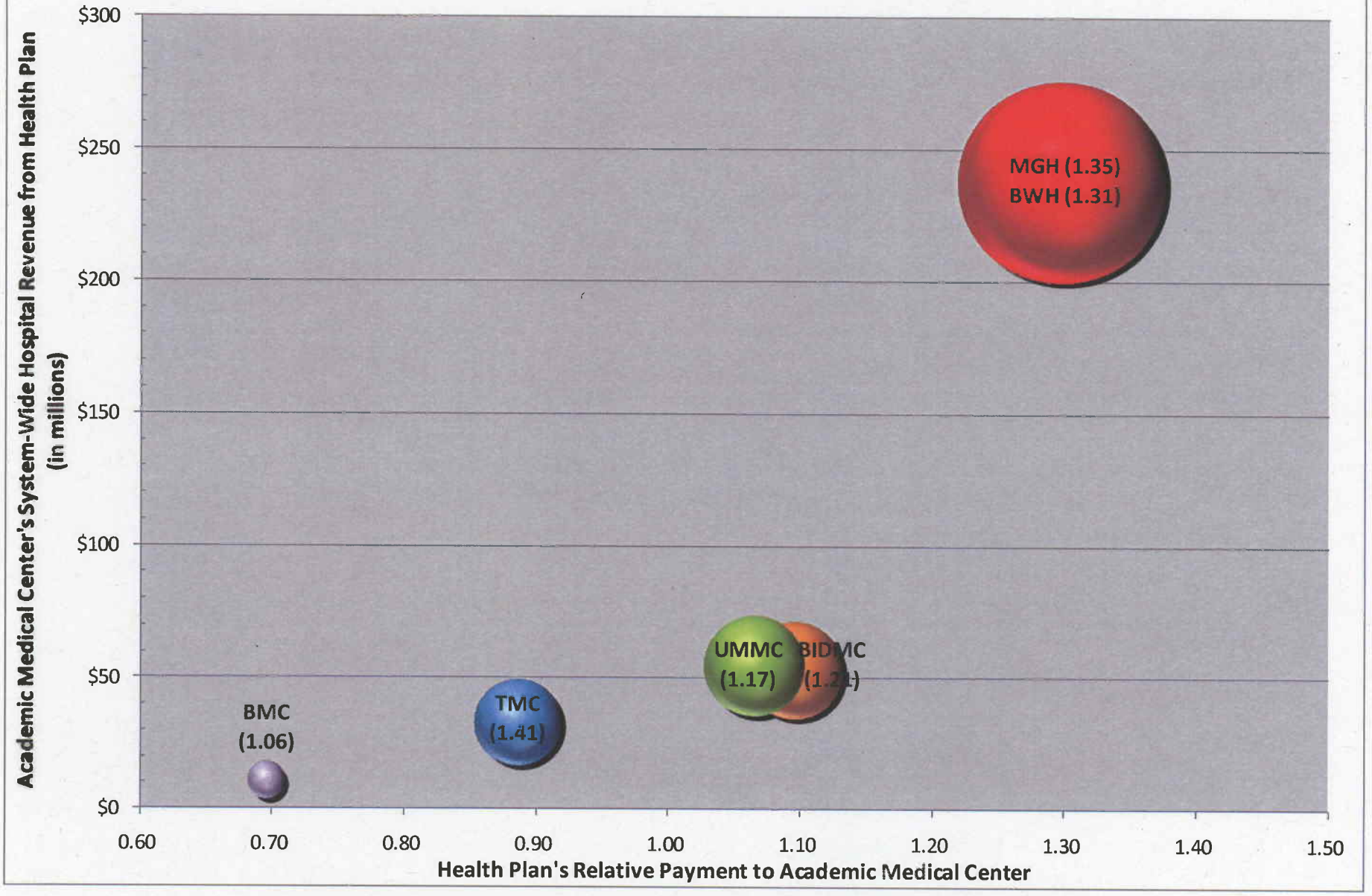
HIGHER PRICES ARE NOT TIED TO TEACHING STATUS

HIGHER PRICES ARE NOT TIED TO INCREASED COMPLEXITY OF SERVICES



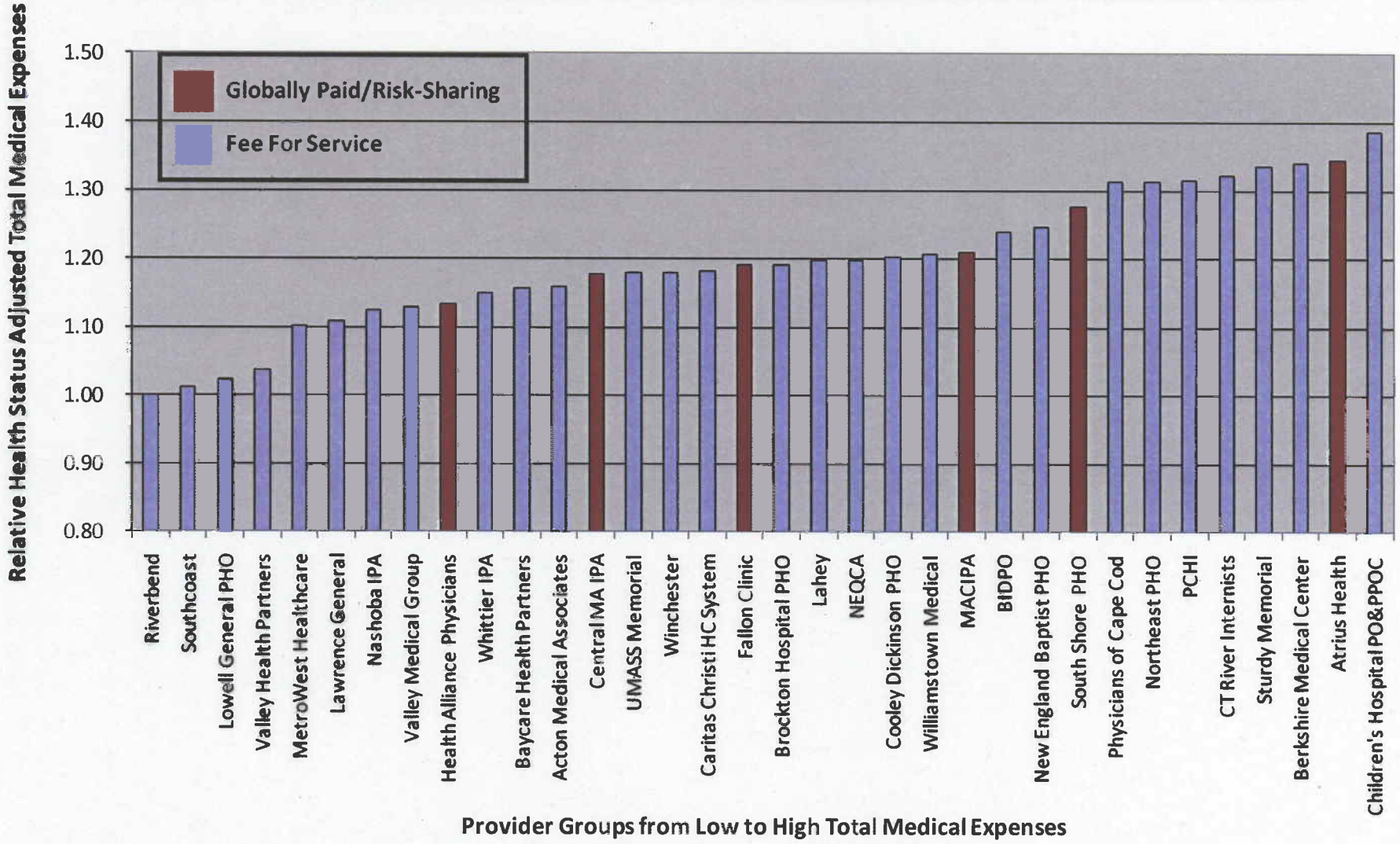
INFORMATION FROM A MAJOR HEALTH PLAN: FOR ILLUSTRATIVE PURPOSES ONLY

HIGHER PRICES CORRELATE WITH GREATER MARKET LEVERAGE



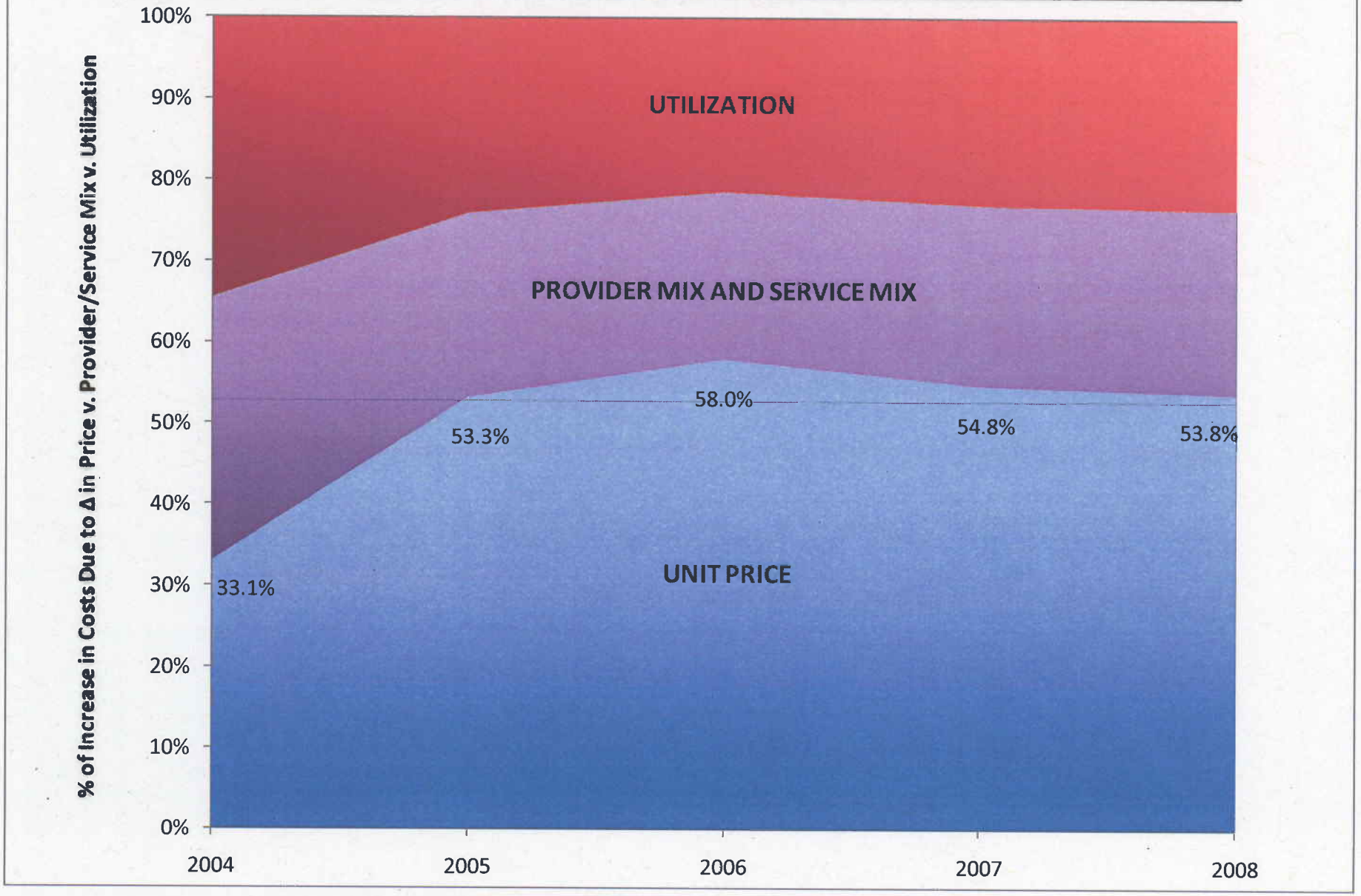
INFORMATION FROM A MAJOR HEALTH PLAN: FOR ILLUSTRATIVE PURPOSES ONLY

TOTAL MEDICAL EXPENSES NOT CORRELATED TO PAYMENT METHOD: TME SOMETIMES HIGHER FOR RISK-SHARING PROVIDERS THAN PROVIDERS PAID ON FEE FOR SERVICE BASIS



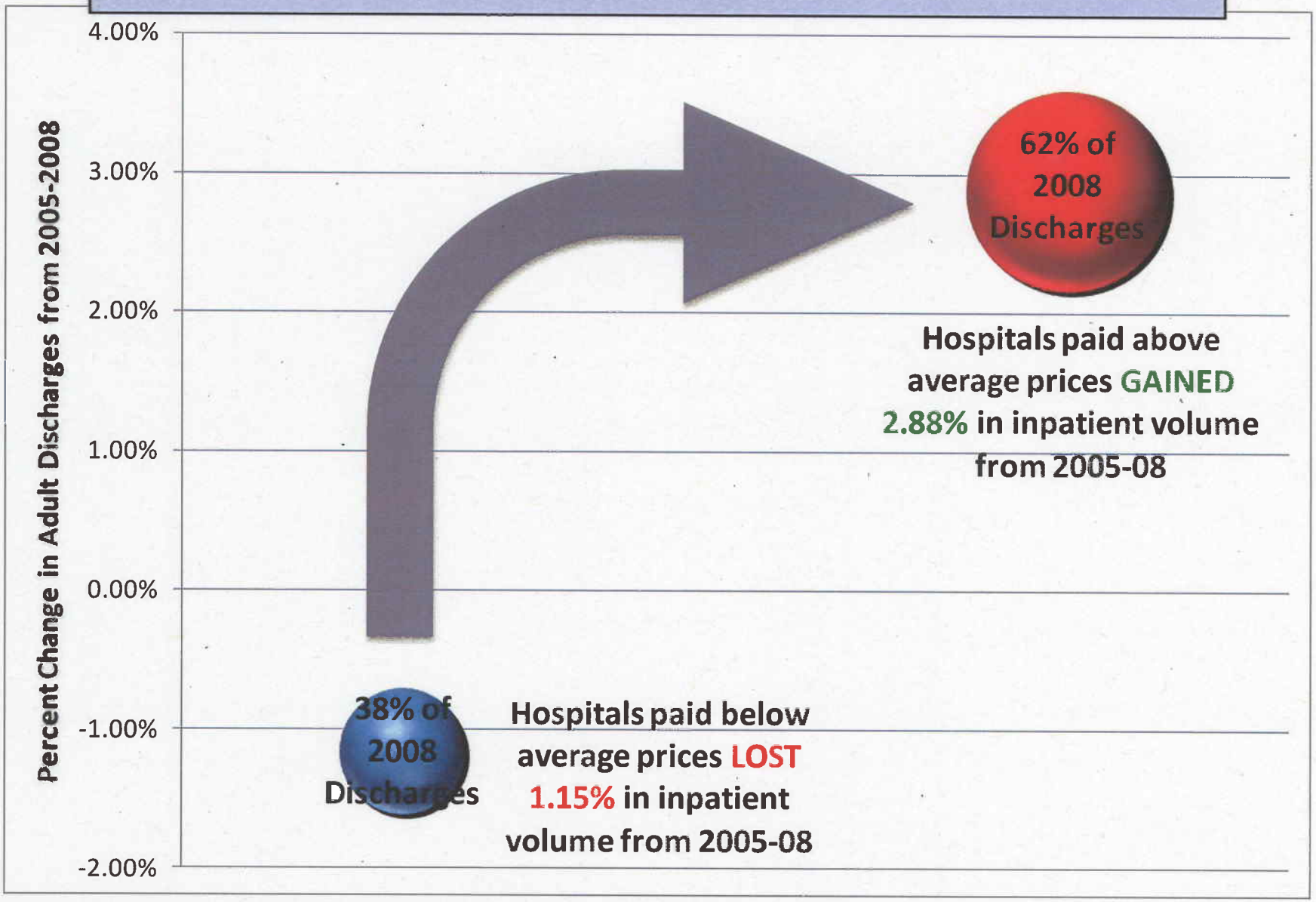
INFORMATION FROM A MAJOR HEALTH PLAN: FOR ILLUSTRATIVE PURPOSES ONLY

PRICE INCREASES CAUSED MOST OF THE INCREASES IN HEALTH CARE COSTS DURING THE PAST FEW YEARS



INFORMATION FROM A MAJOR HEALTH PLAN: FOR ILLUSTRATIVE PURPOSES ONLY

MORE EXPENSIVE PROVIDERS ARE GAINING MARKET SHARE AT THE EXPENSE OF LESS EXPENSIVE PROVIDERS



Note: Statewide discharges increased by 1.3% from 2005 to 2008.

INFORMATION FROM A MAJOR HEALTH PLAN: FOR ILLUSTRATIVE PURPOSES ONLY

Dr. John Freedman

Role of Quality

Bela Gorman, FSA, MAAA

Role of Price

MOVING FORWARD ON COST CONTAINMENT

1. Encourage transparency and standardization in both health care payment and health care quality measures.
2. Mitigate market dysfunction and promote correlation between price and value.
3. Promote prudent purchasing through insurance products and decision-making tools.
4. Reform contracting practices that perpetuate market disparities and inhibit product innovation.

Massachusetts Health Care Cost Trends Final Report

Appendix C.4f

Health Care Cost Trends Public Hearings Presentations

Expert Wtiness: Creating the Framework for High Performing Organizations
Stephen Schoenbaum, M.D., M.P.H.
The Commomnwealth Commission on a High Performance Health System

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Creating the Framework for High Performing Health Care Organizations

Stephen C. Schoenbaum, MD, MPH

Executive Vice President for Programs

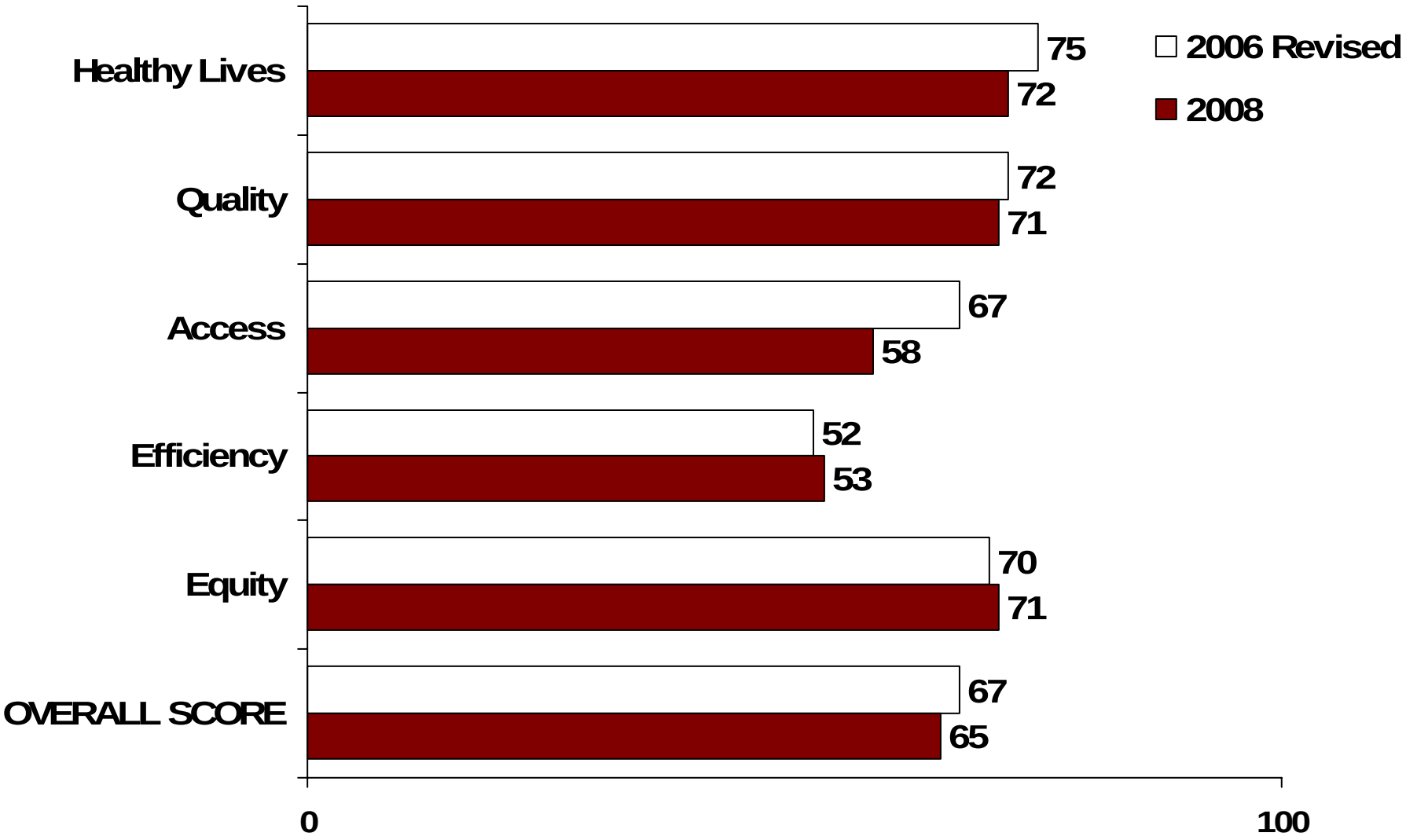
www.commonwealthfund.org

scs@cmwf.org

Public Hearing on Health Care Provider and Payer Costs and Cost Trends

Boston, MA, March 18, 2010

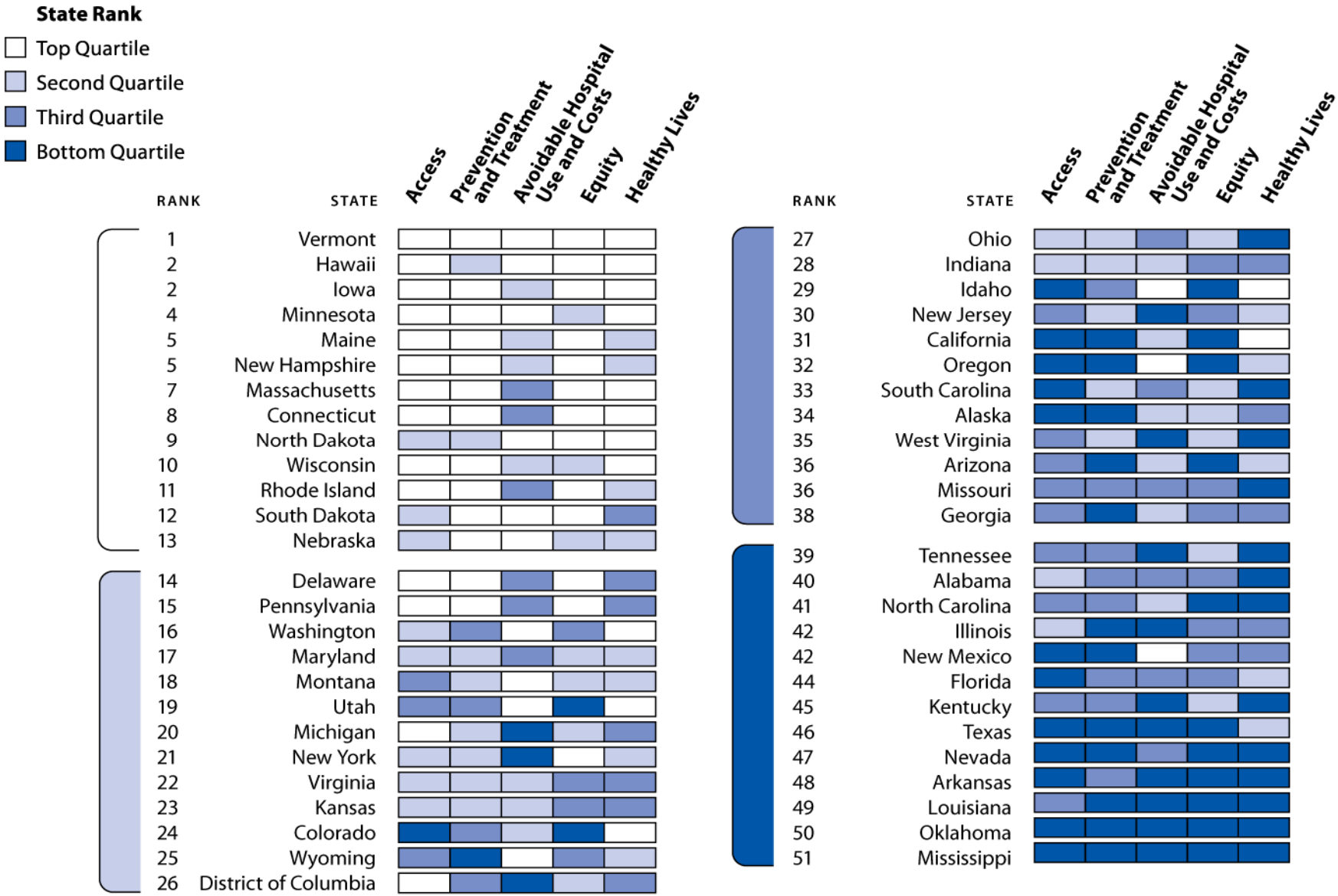
Exhibit 1 - Scores: Dimensions of a High Performance Health System



Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

Exhibit 2:

2009 State Scorecard Summary of Health System Performance



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Exhibit 2A: Five Key Strategies for High Performance

1. Extend affordable health insurance to all
2. Align financial incentives to enhance value and achieve savings
3. Organize the health care system around the patient to ensure that care is accessible and coordinated
4. Meet and raise benchmarks for high-quality, efficient care
5. Ensure accountable national leadership and public/private collaboration

Source: Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, The Commonwealth Fund, November 2007

Exhibit 3: "Organization" & "Quality" Are Related

- **Large practices perform better than solo/small practices**
  - Large practices are twice as likely to engage in quality improvement and utilize EMRs (Audet et al, 2005)
  - Large practices have lower mortality in heart attack care than solo practices (Ketcham et al, 2007)

- **Integrated Medical Groups perform better than IPAs (Independent Practice Associations)**
  - Integrated medical groups have more IT, more QI (quality improvement) programs, and better clinical performance than IPAs (Mehrota et al, 2006)
  - HMOS that use more group or staff model physician networks have higher performance on composite clinical measures (Gillies et al, 2006)

- **Any network affiliation is better than no affiliation**
  - Although integrated medical groups perform better than IPAs, IPAs are still twice as likely to use effective care management processes than small groups with no IPA affiliation (Rittenhouse et al, 2004)
  - Physician group affiliation with networks is associated with higher quality; impact is greatest among small physician groups (Friedberg et al 2007)

Exhibit 4: “Organization”, Cost & Patient Experience

- **Medical groups can be more efficient**
  - Costs are about 25 percent lower in pre-paid group practices than in other types of health plans, but primary data are old (Chuang et al 2004)
  - Physician-to-population ratio is 22-37 percent below the national rate across 8 large pre-paid group practices (Weiner et al, 2004)

OVERALL CONCLUSION:

“Organization” is an enabler, not a guarantee of higher performance

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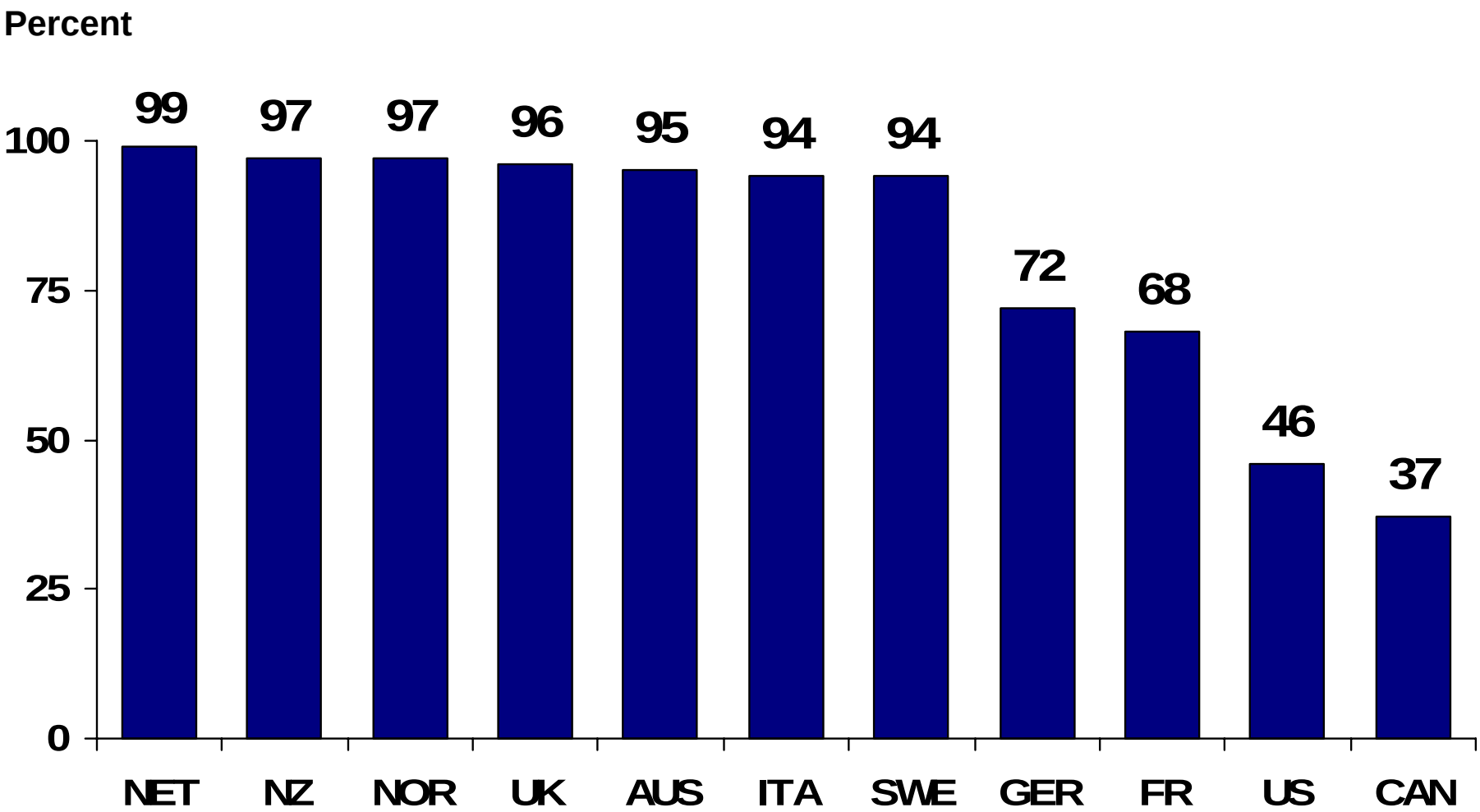
Exhibit 5: Primary Care Doctors Use Electronic Patient Medical Records*



* Not including billing systems.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

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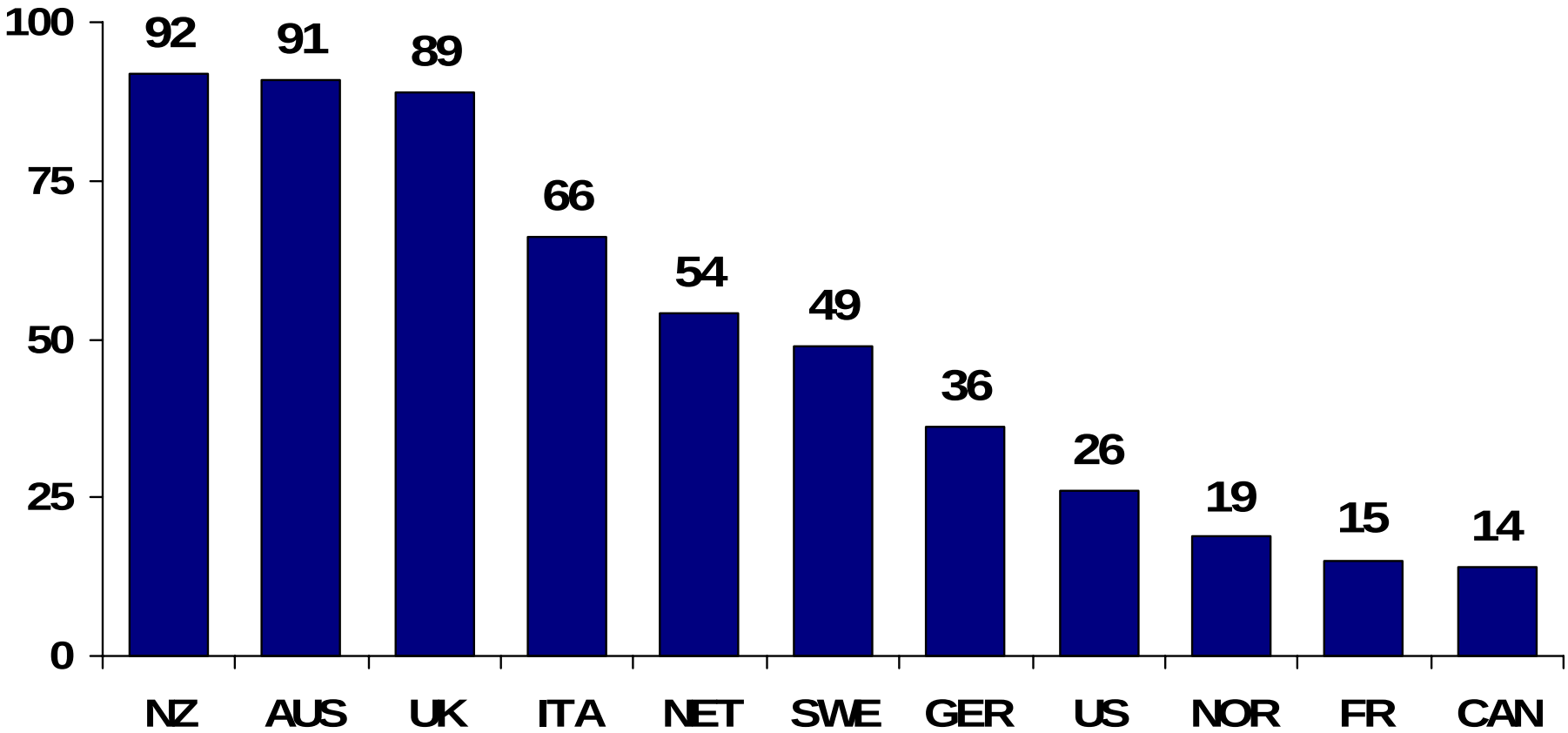
Exhibit 6: Practices with Advanced Electronic Health Information Capacity

Percent reporting at least 9 of 14 clinical IT functions*



* Count of 14 functions includes: electronic medical record; electronic prescribing and ordering of tests; electronic access test results, Rx alerts, clinical notes; computerized system for tracking lab tests, guidelines, alerts to provide patients with test results, preventive/follow-up care reminders; and computerized list of patients by diagnosis, medications, due for tests or preventive care.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

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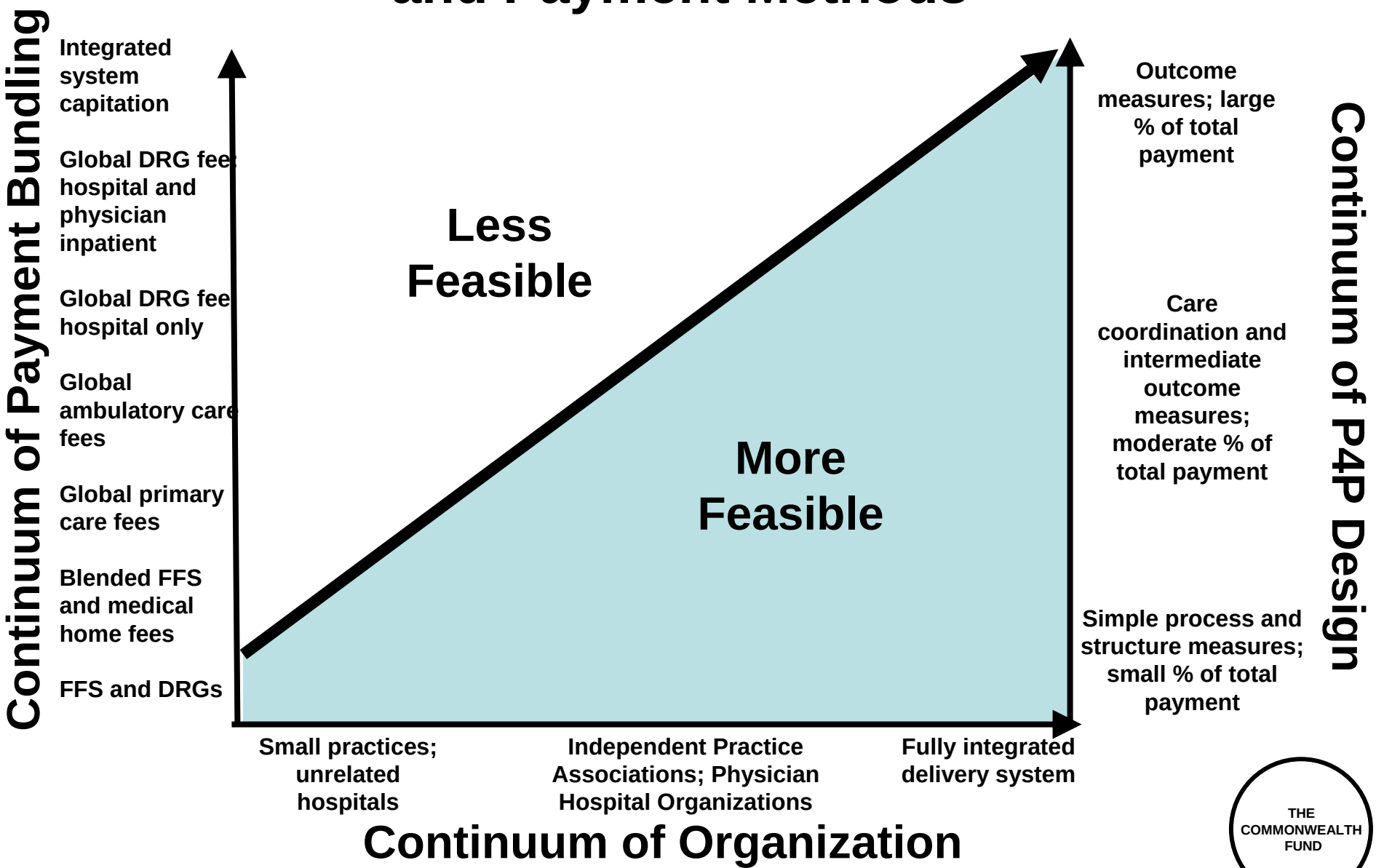
Exhibit 7: The Relationship of Organization Type and Payment Methods



Source: Shih et al, The Commonwealth Fund, August 2008

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Exhibit 8: Fifteen Options that Achieve Savings Cumulative 10-Year Savings

Producing and Using Better Information	
• Promoting Health Information Technology	-$88 billion
• Center for Medical Effectiveness and Health Care Decision-Making	-$368 billion
• Patient Shared Decision-Making	-$9 billion
Promoting Health and Disease Prevention	
• Public Health: Reducing Tobacco Use	-$191 billion
• Public Health: Reducing Obesity	-$283 billion
• Positive Incentives for Health	-$19 billion
Aligning Incentives with Quality and Efficiency	
• Hospital Pay-for-Performance	-$34 billion
• Episode-of-Care Payment	-$229 billion
• Strengthening Primary Care and Care Coordination	-$194 billion
• Limit Federal Tax Exemptions for Premium Contributions	-$131 billion
Correcting Price Signals in the Health Care Market	
• Reset Benchmark Rates for Medicare Advantage Plans	-$50 billion
• Competitive Bidding	-$104 billion
• Negotiated Prescription Drug Prices	-$43 billion
• All-Payer Provider Payment Methods and Rates	-$122 billion
• Limit Payment Updates in High-Cost Areas	-$158 billion

Source: ***Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*****, Commonwealth Fund, December 2007.**
http://www.commonwealthfund.org/usr_doc/Schoen_bendingthecurve_1080.pdf?section=4039

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Visit the Fund: www.commonwealthfund.org

www.whynotthebest.org

- **WhyNotTheBest.org – a new Commonwealth Fund web site for tracking performance & facilitating performance improvement**
- **Enables users to compare their performance with peers, over time, and against a range of benchmarks (currently hospital data)**
- **Offers case studies of high-performing organizations and improvement tools**

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Massachusetts Health Care Cost Trends Final Report

Appendix C.4g

Health Care Cost Trends Public Hearings Presentations

Expert Wtiness: Understanding Cost Drivers in the Health Care System
Paul Ginsburg, Ph.D.
Center for Studying Health System Change

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NATIONAL INSTITUTE FOR HEALTH CARE REFORM

ADVANCING HEALTH POLICY RESEARCH

Addressing Spending Trends in Massachusetts

Paul B. Ginsburg, Ph.D.

Testimony before the Massachusetts Division of Health Care Finance and Policy, March 18, 2010

CENTER for STUDYING HEALTH SYSTEM CHANGE

Valuable Massachusetts Data and Analysis from DHCFP and AG

- Richer than national data
- Shows price to be a key factor in recent trend
- Utilization contributes to trend as well
- Large variation in prices across providers
  - Reflection of market leverage

What Drives Provider Prices? (1)

- Absence of demand-side restraints
  - Extensive third-party payment
  - Purchaser demands for broad choice of providers
    - Limited interest in narrower networks where offered
    - "Must-have" providers face little risk of network exclusion
  - Benefit structures provide few patient incentives to choose low-priced providers
    - Little use of tiering for hospitals/physicians
      - GIC a pioneer in this approach
      - Promising initiative from BCBSMA

What Drives Provider Prices? (2)

- Supply-side issues can be important
  - Degree of excess capacity
  - Degree of provider consolidation
  - Extent of hospital employment/alignment of physicians

Recent National Trend of Growing Provider Leverage

- Trends in supply-side factors increasing market power
  - Greater hospital employment of physicians
  - Increasing consolidation and tighter capacity
  - Medicaid cuts lead to providers increasing use of their leverage to shift costs to private insurers

Recent Trend of Growing Provider Leverage cont.

- MedPAC analysis of Medicare margins, overall margins, costs
  - Medicare fixed payments not constraining costs at strong hospitals

Addressing Rising Prices

- Market and regulatory approaches
  - Not mutually exclusive
    - Regulation could incorporate market forces
  - History in U.S. is reluctance to pursue either
    - Exception is use of administered prices by public payers instead of passive methods to set prices

The Market Approach

- Insurance benefit structures that incent provider choice
  - Example: Vary hospital copay or deductible according to provider chosen
  - Ultimate design is reference pricing
    - Patient pays the difference from low-cost provider

Such Benefit Structures Rare

- CDHP designs include only limited provider-choice incentives
  - Large deductible does not impact inpatient care
  - Some incentives for outpatient tests/procedures
- Tax treatment of health insurance blunts incentives for such designs
- Tiered networks limited by data and by hospital resistance

Role of Price Transparency in Market Approaches

- Under universal coverage, insurer is ideal data source for consumers
  - Focus on provider differences in cost to patients
  - Relevant only with incentives to choose low-cost providers

Role of Price Transparency in Market Approaches cont.

- Unpredictable impact of government posting of negotiated prices
  - Potential constraint of dominant providers through public pressure
  - Potential for higher prices if providers know competitors' prices
    - Extensively documented in other industries

The Regulatory Approach

- Rate setting applicable to private payers
  - Addresses provider leverage issues
  - Potential to lead reform of provider payment
    - Set payment methods for all to use
  - Opportunity for patient incentives to address remaining provider price differences

Rate Setting Challenging to Do Well

- High degree of sophistication needed
  - Current contracting recognizes measured quality and utilization differences
- Governance structure is critical
  - Independence of Maryland Commission a key factor in its long-term success
- Unlikely to achieve large short-term gains in an industry with low margins

Importance of Provider Payment Reform

- Service volume key component of spending trends
- Need for broader payment units covering multiple providers
  - More meaningful units to price
- Key to both market and regulatory approaches
- Massachusetts path to global payment

Importance of Provider Payment Reform contd.

- Range of large and small steps for reform
  - New versions of capitation
    - BCBSMA Alternative Quality Contract
    - Accountable care organizations
  - Per-episode payment for selected episodes
  - Payment to medical homes
  - Incorporate post-acute care into hospital payment
  - Incentives to reduce hospital readmissions

Observation from Interviews

- Theme of our Boston visit was focus on controlling costs
- Boston providers anticipating greater accountability for spending as well as quality
  - Efforts to increase efficiency already underway
  - Reports that AQC contracts spurring changes

Leadership in Provider Payment Reform

- Private payer experimentation
- Potential for Medicare reform
- State development and prescription of payment methods
  - Seek Medicare waiver
- Potential for all-payer rate setting system to lead payment reform

Conclusion

- Great deal at stake in slowing spending trends
- Price and quantity both deserve attention
- Reform of provider payment methods key to substantial “bending the curve”
- Market and regulatory elements can work together

Massachusetts Health Care Cost Trends Final Report

Appendix C.4h

Health Care Cost Trends Public Hearings Presentations

Expert Wtiness: Market Reform Considerations to Reduce the Growth in Health Care Spending

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Testimony of

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Massachusetts Should Be Proud of The Quality of It's Health Care Delivery System and Health Plans

BUT--- *The High Cost of Care Pose Serious Problems---Increasingly Unaffordable and Fewer Non-Healthcare Jobs*

Our Best Hope of Reducing Spending Without Lowering Quality Is To Change The Health Care Delivery System

Any Significant Restructuring of Healthcare Delivery System Will Require A Reimbursement Systems That Supports Such Behavior----

Fee-for-Service System Needs to be Modified or Abandoned!

But How Do We Get From Here *(fee-for-service and Fragmented Care)* to There *(Bundled Payments and Integrated Care)*

Both Private and Public Payment Systems Need To Change and Be Aligned

Market Place Not Capable of Restructuring Payment System

Need To Create A State-Wide Entity To Restructure Payment and Delivery Systems

Need To Include Both Medicare and Medicaid In New Payment System

State Should Seek Waiver from Federal CMS

State-Wide Entity Can Be Part of State Government or A Quasi-Government Organization

Quasi-Government Entity Could Be Modeled After Federal MedPac or Cost Commission in Maryland

Payment Amounts From Each Payer and To Each Provider Start At Current Levels

Over Time Payments to Individual Providers Will Change Based on Their Performance

New Entity To Be Given a 5 Year Charter

Limited Ability for State Government to Intervene

If System Restructured After 5 Years

Could Allow Market To Function--- State Would Set Budget Targets and Evaluate Performance

LET'S LOOK AT A POSSIBLE DELIVERY AND FINANCING SYSTEM REFORM PROPOSAL

REFORM PROPOSAL For MASSACHUSETTS

- Create A New State-Wide Payment System
- All Payers Including Medicare and Medicaid Part of System
- Establish Three Delivery Tiers---
  - Tier One---Fully Integrated ACO Systems
    - Accept Bundle Payments
  - Tier Two--- Virtual Integrated ACO Systems
    - Individual Provider Units Accept Fee-for-Service But Overall Tier Under Budget Target
  - Tier Three– Maintain Fee for Service---No ACO
    - Tier Under Budget Target

REFORM PROPOSAL For MASSACHUSETTS

- State Entity Would Set Global Budget Targets and Quality Standards---Prevent Skimping
- Payments Adjusted for Health Status of Enrollees and Other Community Benefits
- If Total Expenditures for Virtual Groups In Tier II Exceed Targets--- Withholds Not Paid
- Third Tier---Not Participate in Extra Quality Funding and Entire Tier Under Budget Target
- Expect Providers to Transition To Higher Tiers As System Matures

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